I

116TH CONGRESS
1ST SESSION

H. R. 2452

To amend the Social Security Act to establish a Medicare for America health program to provide for comprehensive health coverage for all Americans.

IN THE HOUSE OF REPRESENTATIVES

MAY 1, 2019

Ms. DELAURO (for herself, Ms. SCHAKOWSKY, Mr. KENNEDY, Mr. CLAY, Ms. NORTON, Mr. GRIJALVA, Mr. CARBAJAL, Mrs. TRAHAN, Mr. RYAN, Ms. JACKSON LEE, Mr. THOMPSON of Mississippi, Ms. ROYBAL-ALLARD, Ms. MCCOLLUM, Ms. MOORE, Mr. RUSH, and Mr. HIGGINS of New York) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committees on Energy and Commerce, Education and Labor, the Judiciary, Natural Resources, and House Administration, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend the Social Security Act to establish a Medicare for America health program to provide for comprehensive health coverage for all Americans.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare for America Act of 2019''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—TRANSITIONING TO AND ESTABLISHING MEDICARE FOR AMERICA

Subtitle A—Transitional Public Health Option

SEC. 101. ESTABLISHMENT.

The Secretary of Health and Human Services (in this subtitle referred to as the ''Secretary'') shall establish a public health plan option that is offered in the individual market through the Federal and State Exchanges under title I of the Patient Protection and Affordable Care Act to eligible individuals for plan years 2021 and 2022 in accordance with this subtitle.

SEC. 102. ELIGIBILITY.

Subject to subsection (b), an individual is eligible to enroll in such public health plan option if the individual is otherwise eligible to purchase individual health insurance coverage through an Exchange and the individual resides in a rating area in which the Secretary makes the public health plan option available.

SEC. 103. BENEFITS.

(a) IN GENERAL.—The public health plan option shall be a qualified health plan within the meaning of section 1301(a) of the Patient Protection and Affordable Care Act (42 U.S.C. 18021(a)) that—

(1) meets all requirements applicable to qualified health plans under subtitle D of title I of the Patient Protection and Affordable Care Act (other than the requirement under section 1301(a)(1)(C)(ii) of such Act (42 U.S.C. 18021(a)(1)(C)(ii))) and title XXVII of the Public Health Service Act;

(2) provides coverage of the essential health benefits described in section 1302(b) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(b));

(3) provides silver and gold-level coverage described in section 1302(d)(1)(C) of the Patient Pro-

tection and Affordable Care Act (42 U.S.C. 18022(d)(1)(C)); and

(4) provides coverage of comprehensive reproductive health services, including abortion.

(b) PREEMPTION.—Notwithstanding section 1303(a)(1) of the Patient Protection and Affordable Care Act (42 U.S.C. 18023(a)(1))—

(1) a State may not prohibit the public health plan option from offering the coverage described in subsection (a)(4); and

(2) no State law that would prohibit such a plan from offering such coverage shall apply to such plan.

SEC. 104. PREMIUMS.

(a) IN GENERAL.—The Secretary shall establish premium rates for the public health plan option that—

(1) are adjusted based on the applicable rating area;

(2) are at a level sufficient to fully finance—

(A) the costs of health benefits provided by such plans; and

(B) administrative costs related to operating the plans;

(3) comply with the requirements under section 2701 of the Public Health Service Act (42 U.S.C. 300gg); and

(4) ensure that no individual or household will pay more than 8 percent of adjusted gross monthly income toward the monthly premium.

(b) FEDERAL SUBSIDIES.—Federal subsidies shall be provided to ensure that the premium shall be—

(1) zero in the case of an individual whose annual household income is below 200 percent of the poverty line;

(2) determined by a linear sliding scale, in the case of an individual whose household income is at least 200 percent of the poverty line, but not more than 600 percent of the poverty line; and

(3) no individual or household above 600 percent of poverty level will pay more than 8 percent of adjusted gross monthly income toward such monthly premium.

SEC. 105. PROVIDERS AND REIMBURSEMENT RATES.

(a) IN GENERAL.—The Secretary shall establish a rate schedule for reimbursing types of health care providers furnishing items and services under the public health insurance plan option at rates based on rates applied for such items and services under title XVIII of the

Social Security Act, as of the date of the enactment of this Act, that are necessary to maintain network adequacy. The Secretary shall establish a rate schedule for items and services not currently covered under title XVIII of the Social Security Act, such as dental, vision, and hearing benefits, well child visits, and reproductive health services, at a level to ensure adequate access to providers.

(b) PARTICIPATING PROVIDERS.—

(1) IN GENERAL.—A health care provider that is a participating provider of services or supplier under the Medicare program under title XVIII of the Social Security Act or under the Medicaid program under title XIX of such Act on the date of enactment of this title shall be a participating provider for the public health insurance plan option.

(2) ADDITIONAL PROVIDERS.—The Secretary shall establish a process to allow health care providers not described in paragraph (1) to become participating providers for the public health insurance plan option.

(3) CLARIFICATION.—Notwithstanding any other provision of law, health care providers may not be prohibited from participating in the public health insurance option for reasons other than their ability to provide covered services. Health care providers

and institutions are prohibited from denying covered individuals access to any covered benefits and services because of their religious objections.

(c) PRESCRIPTION DRUGS.—The Secretary shall apply the provisions of section 1860D–11(i) of the Social Security Act (42 U.S.C. 1395w–111(i)) to prescription drugs under the public health plan option in the same manner as such provisions apply with respect to applicable covered part D drugs under such section.

SEC. 106. ACCOUNT; FUNDING.

(a) ESTABLISHMENT.—There is established in the Treasury of the United States an account for the receipts and disbursements attributable to the operation of the public health plan option.

(b) APPROPRIATION.—There is appropriated to the account established under subsection (a), out of any funds in the Treasury not otherwise obligated, such sums as may be necessary to be used by the Secretary for purposes of carrying out this part.

(c) PROHIBITION OF STATE IMPOSITION OF TAXES.—Section 1854(g) of the Social Security Act (42 U.S.C. 1395w–24(g)) shall apply to receipts and disbursements described in subsection (a) in the same manner as such section applies to payments or premiums described in such section.

(d) CLARIFICATION.—Any provision of law restricting the use of Federal funds with respect to any reproductive health service shall not apply to funds appropriated under subsection (b) or with respect to the account under subsection (a).

Subtitle B—Medicare for America

SEC. 111. ESTABLISHMENT AND ADMINISTRATION OF MEDICARE FOR AMERICA.

The Social Security Act is amended by adding at the end the following new title:

"TITLE XXII—MEDICARE FOR AMERICA

"PART A—COMPREHENSIVE HEALTH COVERAGE

"SEC. 2201. ESTABLISHMENT.

''The Secretary shall establish a public health insurance program, to be known as 'Medicare for America', which shall for calendar year 2023 and each subsequent calendar year provide comprehensive health benefits in accordance with this part to individuals enrolled for coverage under this title.

"SEC. 2202. ELIGIBILITY; AUTOMATIC ENROLLMENT.

''(a) ELIGIBLE INDIVIDUALS.—For purposes of this title, every individual who is—

''(1) a resident of the United States or a territory of the United States;

''(2) an individual who is lawfully present, as defined in section 152.2 of title 45 of the Code of Federal Regulations; or

''(3) an individual who would be eligible for coverage under a State Medicaid plan pursuant to section 1903(v) (as such section was in effect as of the date of the enactment of this title),

is entitled to benefits for health care services under this title. The Secretary shall promulgate a rule that provides criteria for applying this subsection, including determining residency for eligibility purposes under this title. Nothing in this title shall preclude a State from using State funds to provide for an individual's health coverage who is not eligible under this subsection.

''(b) ENROLLMENTS.—Subject to subsection (c):

''(1) IN GENERAL.—Beginning in 2023, the Secretary shall provide a mechanism for the enrollment of individuals entitled to benefits under this title and, in conjunction with such enrollment, the issuance of a Medicare for America card which may be used for purposes of identification and processing of claims for benefits under this title. The card shall not use the individual's social security number as an identifier. As a condition of participation in the program, participating providers shall facilitate enroll-

ment as specified by the Secretary. The State entities responsible for enrolling individuals in the Medicaid program under title XIX and the Children's Health Insurance Program under title XXI shall serve as the enrolling entity for Medicare for America within each State.

''(2) AUTOMATIC ENROLLMENTS.—The mechanism provided under paragraph (1) shall, subject to paragraph (4), provide, for plan years, for the following automatic enrollments under Medicare for America:

''(A) ENROLLMENT AT BIRTH.—For plan years (beginning with plan year 2023), a process, established by the Secretary in consultation with the Commissioner of Social Security, for the automatic enrollment of eligible individuals born during such plan year.

''(B) CURRENT MEDICARE BENEFICIARIES.—

''(i) CURRENT MEDICARE BENEFICIARIES.—For plan years (beginning with plan year 2023), a process established by the Secretary for the automatic enrollment of all individuals who are enrolled for benefits under part A or B of title XVIII

(other than individuals who are enrolled for such benefits and receiving benefits under title XIX).

''(ii) CONTINUING POPULATION.—For plan years (beginning with plan year 2023), a process established by the Secretary for the automatic enrollment of eligible individuals who attain the age of 65 during such plan year.

''(iii) DUALS.—For plan years (beginning with plan year 2025), a process established by the Secretary for the automatic enrollment of eligible individuals who are enrolled for benefits under part A or B of title XVIII and receiving benefits under title XIX.

''(C) OTHER INDIVIDUALS WITHOUT QUALIFIED HEALTH COVERAGE.—For plan years (beginning with plan year 2023), a process established by the Secretary for the automatic enrollment of eligible individuals who are not enrolled in other qualified health coverage (as defined in paragraph (4)(B)) for such plan year.

''(3) OTHER ENROLLMENTS.—The mechanism provided under paragraph (1) shall provide for the following:

''(A) IN GENERAL.—Enrollment periods and processes for each plan year (beginning with plan year 2023) for enrollment under Medicare for America of any eligible individual not otherwise described in paragraph (2).

''(B) SMALL EMPLOYERS.—

''(i) IN GENERAL.—For plan years (beginning with plan year 2023), a process and methodology under which a small employer, as defined in section 126(d)(3) of the Medicare for America Act, may provide for the enrollment of the employees of such employer under Medicare for America. For purposes of this subparagraph, the term 'small employer' means any employer for any calendar year if the annual payroll of such employer for the preceding calendar year does not exceed $2,000,000 or has fewer than 100 employees.

''(ii) REQUIREMENT.—Small employers shall either provide coverage as defined within the meaning of section 2791(d)(8)

of the Public Health Service Act or facilitate the enrollment of their employees into Medicare for America. Small employers facilitating enrollment into Medicare for America will not be subject to a mandatory employer contribution.

''(iii) AUTHORITY.—The Secretary may set standards for determining whether employers are undertaking any actions to affect the risk pool within Medicare for America by inducing individuals to decline coverage under a qualifying employer-sponsored plan and instead to enroll in Medicare for America. An employer violating such standards shall be treated as not meeting the requirements of qualified health coverage.

''(C) LARGE EMPLOYERS.—For plan years (beginning with plan year 2027), the Secretary shall provide for a process and methodology under which a large employer may provide for the enrollment of the employees of such employer under Medicare for America. For purposes of the preceding sentence, the term 'large employer' means an employer with at least 100

employees or whose annual payroll exceeds $2,000,000.

"(D) MEMBERS OF CONGRESS AND THEIR STAFF.—Beginning for plan year 2023, Members of Congress and their staff, subject to paragraph (4), shall be enrolled in Medicare for America.

"(4) OPT OUT FOR INDIVIDUALS ENROLLED UNDER QUALIFIED HEALTH COVERAGE.—

"(A) IN GENERAL.—The mechanism provided under paragraph (1) shall provide, with respect to a plan year, for a process that enables individuals who are enrolled in qualified health coverage for such plan year to opt out of coverage under Medicare for America for such year.

"(B) QUALIFIED HEALTH COVERAGE DEFINED.—For purposes of this section, the term 'qualified health coverage' means coverage under any of the following:

"(i) For plan years 2023 and 2024:

"(I) Qualified employer coverage, as defined in section 126 of the Medicare for America Act.

"(II) Medical coverage under chapter 55 of title 10, United States Code, including coverage under the TRICARE program.

"(III) A health care program under chapter 17 or 18 of title 38, United States Code, as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of Health and Human Services and the Secretary.

"(IV) The health benefit program under chapter 89 of title 5, United States Code.

"(V) Medical benefits and services provided by or through the Indian Health Service.

"(VI) The Medicaid program under title XIX of the Social Security Act.

"(VII) The CHIP program under title XXI of the Social Security Act.

"(ii) For plan years 2025 and 2026:

"(I) Coverage described in subclause (I), (II), (III), (IV), or (V) of clause (i).

"(II) Coverage described in subclause (VI) of clause (i), but only with respect to coverage that is not for individuals described in subclause (VIII) of section 1902(a)(10)(A)(i) or who are also enrolled for benefits under title XVIII.

"(iii) For each subsequent plan year, coverage described in subclause (I), (II), (III), (IV), or (V) of clause (i).

"(c) WAIVER.—The Secretary shall establish a process under which the Secretary may grant waivers to States for additional time before populations described in a previous subsection of this section of such State are automatically enrolled under Medicare for America so long as the State can demonstrate substantial progress has been made in transitioning these populations.

"SEC. 2203. BENEFITS.

"(a) IN GENERAL.—Medicare for America shall, in accordance with this section, provide coverage for all the benefits, as determined to be medically necessary, as covered and defined under parts A and B of title XVIII and

title XIX as of the date of the enactment of this title, including the following:

''(1) Ambulatory patient services.

''(2) Emergency care and urgent care services.

''(3) Hospitalization.

''(4) Maternity and newborn care.

''(5) Behavioral health services, including mental health, substance use disorder services, and intensive home and community based services.

''(6) Prescription drugs approved by the Food and Drug Administration.

''(7) Rehabilitative and habilitative services and devices, including the following:

''(A) Physical therapy.

''(B) Speech therapy.

''(C) Occupational therapy.

''(8) Laboratory services.

''(9) Preventive and wellness services and chronic disease management.

''(10) Pediatric services, all services that would otherwise be coverable under early and periodic screening, diagnostic, and treatment under the Medicaid program under title XIX and services otherwise included under the maternal, infant, and early child-

hood home visiting program under section 511, as of the date of the enactment of this title.

''(11) Dental care, at a minimum the services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions, nightguards, mouthguards, and dentures.

''(12) Hearing health services including aids and exams.

''(13) Vision services.

''(14) Home and community based long-term services and supports.

''(15) Chiropractic services.

''(16) Durable medical equipment (as defined for purposes of title XIX), including the following:

''(A) Wheelchairs and accessories.

''(B) Walking aides such as walkers, canes, and crutches.

''(C) Bathroom equipment such as commodes and safety equipment.

''(D) Inhalation therapy equipment such as nebulizers.

''(E) Hospital beds and accessories.

''(F) Other devices such as Continuous Positive Airway Pressure (CPAP) machines, apnea monitors, and ventilators.

''(G) Insulin pumps and glucometers.

''(H) Breast pumps.

''(I) Lymphedema compression treatment items.

''(J) Wigs for medical conditions.

''(K) Augmentative and alternative communication devices, including dual-use devices.

''(L) Oxygen.

''(M) Orthotic and prosthetic devices.

''(N) Disposable medical supplies.

''(17) Family planning, including the following:

''(A) Reproductive health exams.

''(B) Patient counseling and education related to family planning.

''(C) Abortion.

''(D) Screening, testing, treatment, and pre- and post-test counseling for sexually transmitted diseases and HIV.

''(E) Contraceptives including pill, patch, medication, condom, implant, or other devices used to prevent pregnancy.

''(F) Voluntary sterilization for beneficiaries over the age of 21.

''(G) Infertility treatment.

''(18) Gender-confirming medical procedures and treatment.

''(19) Screening, testing, treatment, and pre- and post-test counseling for sexually transmitted diseases and HIV.

''(20) Dietary and nutrition counseling.

''(21) Medically necessary food and vitamins for digestive and inherited metabolic disorders.

''(22) Nursing facilities.

''(23) Acupuncture.

''(24) Digital health therapeutics, as approved by the Center for Healthcare and the Center for Medicare and Medicaid Innovation.

''(25) Telehealth.

''(26) Non-emergency medical transportation.

''(27) Care coordination, including services defined in section 440.169 of title 42, Code of Federal Regulations.

''(28) Palliative care.

''(29) Any additional benefit or service not included in this section that is coverable by any State

plan (or waiver of such State plan) under title XIX on the date of the enactment of this title.

''(b) UPDATES.—Benefits coverable under Medicare for America shall be updated in accordance with the National Coverage Determination process that had, as of the date before the date of the enactment of this title, applied with respect to benefits covered under title XVIII.

''(c) IMPLEMENTING POLICIES.—The Secretary shall establish payment models, quality measures, and other implementing policies that provide further access to the coverage under this title. For purposes of the previous sentence, the Secretary shall consult with stakeholders, including those covering pediatrics, disabilities, and seniors.

''(d) PROHIBITION AGAINST DUPLICATING COVERAGE.—

''(1) IN GENERAL.—It is unlawful for a private health insurer (other than an insurer with respect to a Medicare Advantage for America plan under part C of this title or qualified employer-based coverage) to sell health insurance coverage that duplicates the benefits provided under Medicare for America under this part.

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as prohibiting the sale of health insurance coverage for any additional benefits

not covered by this part, insofar as the coverage satisfies the conditions of paragraphs (3) and (4). Nothing shall preclude employers meeting the requirements under section 126 of the Medicare for America Act from providing supplemental coverage under this section to their employees.

''(3) APPLICATION OF PROTECTIONS.—For purposes of paragraph (2), health insurance coverage for any additional benefits must satisfy the following conditions:

''(A) The provisions of section 2718 of the Public Health Service Act, relating to a medical loss ratio.

''(B) The provisions of section 2702 of the Public Health Service Act, relating to guaranteed issue.

''(C) The provisions of section 2701 of the Public Health Service Act, relating to community rating.

''(D) The provisions of section 2704 of the Public Health Service Act, relating to the ban on pre-existing conditions exclusions.

''(4) NO FEES TO BROKERS.—For purposes of paragraph (2), the condition described in this paragraph is that health insurance coverage described in

such paragraph does not pay fees to insurance brokers.

''(e) STATES MAY PROVIDE ADDITIONAL BENEFITS.—Individual States may provide additional benefits for the residents of such States at the expense of the State.

''(f) PROHIBITION AGAINST STEP THERAPY AND PRIOR AUTHORIZATION.—Items and services covered under Medicare for America shall be covered without any need for any prior authorization determination and without any limitation applied through the use of step therapy protocols.

''SEC. 2204. PREMIUMS.

''(a) IN GENERAL.—

''(1) IN GENERAL.—Subject to paragraph (2), each individual enrolled for benefits under this title for a year shall pay monthly community-rated premiums for such year in an amount determined by the Secretary in accordance with subsection (b).

''(2) GRANDFATHERED MEDICARE BENEFICIARIES.—In the case of an individual enrolled under part B of title XVIII as of the date of the enactment of this part, the premium applied under this section for such individual for benefits under this title shall be the lesser of—

''(A) the premium otherwise applicable to such individual under such title XVIII if this title had not been enacted; or

''(B) the premium that would be applied to such individual under this title without the application of this paragraph.

''(b) PREMIUM CONTRIBUTION BASED ON INCOME.—The amount of a monthly premium, with respect to a plan year (beginning with 2023), under this section shall be established by the Secretary in accordance with the following:

''(1) Such premium shall be determined such that the collective premiums for the plan year are with respect to the costs of health benefits provided under this title for such year and related administrative costs.

''(2) Premiums shall vary by family composition only.

''(3) Federal subsidies shall be provided to ensure that the premium shall be—

''(A) zero in the case of an individual whose annual household income is below 200 percent of the poverty line;

''(B) determined by a linear sliding scale, in the case of an individual whose household in-

come is at least 200 percent of the poverty line, but not more than 600 percent of the poverty line; and

''(C) no individual or household will pay more than 8 percent of adjusted gross monthly income toward such premium.

''(4) For an individual whose employer will be making a firm-wide contribution under this title in lieu of offering employer-sponsored insurance (as specified in section 126(b)(1)(B) of the Medicare for America Act), such individual shall pay a premium in accordance with this subsection.

''(5) For an individual who has opted out of their employer-sponsored insurance in order to enroll in Medicare for America as specified in section 126(c) of such Act, the individual shall pay the lesser of—

''(A) the premium described in this subsection; or

''(B) the amount owed after the amount of employer contribution (as specified in section 126(b)(1)(B) of the Medicare for America Act) is subtracted from the premium established by the Secretary of Health and Human Services as described in paragraph (1), whichever is less.

''(c) DEPOSITS.—Amounts paid under this section for coverage under this title shall be deposited in the Treasury to the credit of the Trust Fund established under section 2206.

''(d) APPEALS FOR CERTAIN MEDICARE GRANDFATHERED POPULATION.—In calculating premiums for purposes of subsection (a)(2):

''(1) Any individual that was subject to a late enrollment penalty under part B of title XVIII shall have the right to appeal the assessment of the penalty for good faith enrollment mistakes.

''(2) The Secretary, in consultation with the Commissioner of Social Security, shall develop and publish a formal application for requesting an action of the Secretary under paragraph (1) to correct or eliminate the effects of an error, misrepresentation, or inaction described in such paragraph and determine and publish specific timelines for timely resolution of such a request.

''(3) The Secretary shall also require that all such determinations with respect to such requests shall be reached within 15 business days of the submission of such application. All determinations shall be in writing through a standard decision notice

which shall include an explanation of the reasons for the determination.

''(4) The Commissioner of Social Security shall enter into contracts with independent review organizations in accordance with this subsection for the purpose of reviewing and determining individual appeals of determinations under paragraph (3) with respect to an application relating to enrollment under part A or part B.

''(5) An individual who receives an adverse determination under paragraph (3) may appeal to an independent review organization designated by the Commission. Any such appeal must be sent to the independent review organization within 90 days of the date the individual received the determination to be eligible for review. The independent review organization shall review and reach a determination of the review in writing within 45 days of the receipt of any such appeal.

''(6) The Secretary of the Treasury may not enter into a contract under paragraph (4) with an independent review organization—

''(A) unless the organization has staff that has the appropriate knowledge of, and experience with, the eligibility and coordination of

benefits rules and regulations under this title; and

''(B) to the extent the organization is a fiscal intermediary under section 1816, a carrier under section 1842, or a Medicare administrative contractor under section 1874A.

''(7) The Secretary shall provide for access by independent review organizations conducting appeal determinations under this subsection, to the database of the Coordination of Benefits Contractor of the Centers for Medicare & Medicaid Services as necessary in order to conduct the duties of such organizations to determine appeals pursuant to this subsection.

''SEC. 2205. PAYMENT OF BENEFITS; COST-SHARING; OUT-OF-POCKET LIMITS.

''(a) PAYMENT OF BENEFITS; COST-SHARING.—There shall be paid, in the case of each individual who is enrolled under Medicare for America and incurs expenses for items and services with respect to which benefits are payable under this part, subject to subsection (c), 80 percent of the reimbursement rates established pursuant to section 2206 for such items and services, except that for the following services, the amounts paid under this section shall be equal to 100 percent of the reimburse-

ment rates established pursuant to section 2206 for such items and services:

''(1) USPTF recommended preventive and chronic disease services.

''(2) Long-term services and supports.

''(3) Generic drugs, and prescription drugs if medically necessary.

''(4) All services for individuals who are medically frail or otherwise have special medical needs, (including children with serious emotional disturbance and adults with serious mental illness), individuals with chronic substance use disorders, or individuals with serious and complex medical conditions (such as epilepsy and HIV), individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living.

''(5) Pregnancy related services.

''(6) Emergency services.

''(7) Services for children under age 21.

The Secretary shall establish a default monthly payment plan under the Medicare for America benefits package to ensure the payment owed by the individual enrolled under Medicare for America is spread-out evenly throughout the year.

''(b) DEDUCTIBLE.—There shall be no deductible under Medicare for America.

''(c) MAXIMUM OUT-OF-POCKET LIMIT.—

''(1) IN GENERAL.—The coverage under Medicare shall provide benefits, after the eligible individual has incurred out-of-pocket expenses for items and services with respect to which benefits are payable under this part in a year equal to the annual out-of-pocket threshold specified in paragraph (2), with cost-sharing that is equal to $0.

''(2) ANNUAL OUT-OF-POCKET THRESHOLD.—

''(A) IN GENERAL.—For purposes of paragraph (1), subject to subparagraphs (B) and (C), the annual out-of-pocket threshold specified in this paragraph is a threshold that shall be determined on a linear sliding scale for household income that is at least 200 percent of the poverty line, but not more than 600 percent of the poverty line, and that shall not exceed—

''(i) with respect to an individual, $3,500; or

''(ii) with respect to a household, $5,000.

Individuals or households with income above 600 percent of the Federal poverty line shall

have their annual out-of-pocket threshold capped at $3,500 and $5,000 respectively.

''(B) INDEXING.—In the case of plan years beginning after 2021, the threshold described in subparagraph (A) (as in effect for the preceding plan year after application of this subparagraph) shall be increased by the percentage increase over the previous year in the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average), published by the Bureau of Labor Statistics.

''(C) EXCEPTION.—For purposes of paragraph (1), the annual out-of-pocket threshold for individuals and households with annual income below 200 percent of the Federal poverty line is $0.

''(d) NO LIFETIME OR ANNUAL LIMITS.—There shall be no lifetime or annual limits for any services or benefits coverable under Medicare for America.

''(e) NO BALANCE BILLING.—No provider may impose a charge to an enrolled individual for coverable services for which benefits are provided under this part in an amount higher than the reimbursement rate for such services under section 2206 and may not impose a charge to

such individual for such service other than with respect to the other cost-sharing described in this section.

''(f) NO PRIVATE CONTRACTING.—A health care provider or health care institution are prohibited from entering into a private contract with an individual enrolled under Medicare for America for any item or service coverable under Medicare for America.

''(g) LIMITATIONS ON THE USE OF FLEXIBLE SAVINGS ACCOUNTS.—Flexible Savings Accounts shall only be used for benefits and services not covered by Medicare for America.

"SEC. 2206. PROVIDERS NETWORK AND REIMBURSEMENT RATES.

''(a) IN GENERAL.—The Secretary shall establish a rate schedule for reimbursing types of health care providers furnishing items and services under Medicare for America at rates that are consistent with subsection (b) and are necessary to maintain network adequacy.

''(b) RATES.—

''(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the Secretary shall establish rates for benefits and services to be provided to health care providers and suppliers furnishing under Medicare for America based on rates that would be applied (including as computed, updated, and ad-

justed) under title XVIII or title XIX, whichever is higher, for such type of health care providers and suppliers and item and service if such title remained in effect and, in the case of a type of provider and supplier or item or service coverable under Medicare for America but not otherwise coverable under title XVIII or title XIX, shall provide for rates that ensure adequate access to care.

''(2) EXCEPTIONS.—For purposes of this section, in applying paragraph (1) the Secretary shall ensure that rates to hospitals for inpatient services or outpatient services furnished under Medicare for America are at least 110 percent of such rates on average or in the aggregate for furnishing such inpatient or outpatient services otherwise applied under title XVIII or title XIX, whichever is higher, except that for hospitals serving underserved areas as specified by the Secretary, such rates are increased as necessary to ensure adequate access to care.

''(3) APPLICATION.—In applying rates under title XVIII and title XIX, as applicable, for purposes of this part, the following shall apply:

''(A) The Secretary shall provide for site-neutral payments for items and services furnished in an outpatient hospital and physician

office, the rate of payment for such service shall be the same.

''(B) The Secretary shall provide for a mechanism to provide payments for direct and indirect costs of graduate medical education programs without any cap on the number of residency positions for which payment may be made, including payments to hospitals for such programs and to eligible facilities for programs for population health-based residencies and for nurse practitioner post-licensure clinical training, residency, and fellowship programs.

''(C) The Secretary shall increase the average relative value of primary care and other mental and behavioral health and cognitive services by not less than 30 percent in order to ensure adequate access to inpatient and outpatient care.

''(D) As a condition of participation in the program, participating providers shall accept Medicare for America rates paid by employer-sponsored insurance plans and Medicare Advantage for America plans.

''(E) The Secretary shall semiannually review if the rates paid by Medicare for America

are creating barriers to care. The Secretary shall have the authority to raise rates as necessary to ensure adequate access to care.

''(4) INCREASED FEDERAL MATCH FOR MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM FOR YEARS 2023 THROUGH 2027.—The Secretary of Health and Human Services shall pay the difference between the Medicare for America rates and the Medicaid and CHIP rates during the period beginning on January 1, 2023, and ending on December 31, 2027.

''(c) PARTICIPATING PROVIDERS.—

''(1) IN GENERAL.—A health care provider that is a participating provider of services or supplier under the Medicare program under title XVIII or the Medicaid program under title XIX on the date of enactment of this title shall remain a participating provider for Medicare for America.

''(2) ADDITIONAL PROVIDERS.—The Secretary shall establish a process to allow health care providers not described in paragraph (1) to become participating providers for Medicare for America.

''(d) PRESCRIPTION DRUGS.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary shall, for plan years

beginning on or after the date of the enactment of this title, negotiate with pharmaceutical manufacturers the prices (including discounts, rebates, and other price concessions) that may be charged to Medicare for America and MA for America organizations during a negotiated price period (as specified by the Secretary) for covered drugs for Medicare for America enrollees. In negotiating such prices under this section, the Secretary shall take into account the following factors:

''(A) The comparative clinical effectiveness and cost effectiveness, when available from an impartial source, of such drug.

''(B) The budgetary impact of providing coverage of such drug.

''(C) The number of similarly effective drugs or alternative treatment regimens for each approved use of such drug.

''(D) The associated financial burden on patients that utilize such drug.

''(E) The associated unmet patient need for such drug.

''(F) The total revenues from global sales obtained by the manufacturer for such drug

and the associated investment in research and development of such drug by the manufacturer.

''(2) FINALIZATION OF NEGOTIATED PRICE.—The negotiated price of each covered drug for a negotiated price period shall be finalized not later than 30 days before the first plan year in such negotiated price period.

''(3) COMPETITIVE LICENSING AUTHORITY.—

''(A) IN GENERAL.—Notwithstanding any exclusivity under clause (iii) or (iv) of section 505(j)(5)(F) of the Federal Food, Drug, and Cosmetic Act, clause (iii) or (iv) of section 505(c)(3)(E) of such Act, section 351(k)(7)(A) of the Public Health Service Act, or section 527(a) of the Federal Food, Drug, and Cosmetic Act, or by an extension of such exclusivity under section 505A of such Act or section 505E of such Act, and any other provision of law that provides for market exclusivity (or extension of market exclusivity) with respect to a drug, in the case that the Secretary is unable to successfully negotiate an appropriate price for a covered drug for a negotiated price period, the Secretary shall authorize the use of any patent, clinical trial data, or other exclusivity granted

by the Federal Government with respect to such drug as the Secretary determines appropriate for purposes of manufacturing such drug for sale under Medicare for America. Any entity making use of a competitive license to use patent, clinical trial data, or other exclusivity under this section shall provide to the manufacturer holding such exclusivity reasonable compensation, as determined by the Secretary based on the following factors:

''(i) The risk-adjusted value of any Federal Government subsidies and investments in research and development used to support the development of such drug.

''(ii) The risk-adjusted value of any investment made by such manufacturer in the research and development of such drug.

''(iii) The impact of the price, including license compensation payments, on meeting the medical need of all patients.

''(iv) The relationship between the price of such drug, including compensation payments, and the health benefits of such drug.

''(v) Other relevant factors determined appropriate by the Secretary to provide reasonable compensation.

''(B) REASONABLE COMPENSATION.—The manufacturer described in subparagraph (A) may seek recovery against the United States in the United States Court of Federal Claims.

''(C) INTERIM PERIOD.—

''(i) IN GENERAL.—Until 1 year after a drug described in subparagraph (A) is approved under section 505(j) of the Federal Food, Drug, and Cosmetic Act or section 351(k) of the Public Health Service Act and is provided under license issued by the Secretary under such subparagraph, Medicare for America shall not pay more for such drug than the average of the prices available, during the most recent 12-month period for which data is available prior to the beginning of such negotiated price period, from the manufacturer to any wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity in the ten OECD (Organization for Economic Cooperation and

Development) countries that have the largest gross domestic product with a per capita income that is not less than half the per capita income of the United States or the price established by the Prescription Drug and Medical Device Review Board established under title III of the Medicare for America Act of 2019.

''(ii) FEDERAL PROGRAM LICENSING.—If such drug is not made available at the price determined, the Secretary shall authorize such entities to use any patent, clinical trial data, or other exclusivity granted by the Federal Government with respect to such drug as the Secretary determines appropriate for purposes of manufacturing such drug for sale under any Federal program, including those provided by Medicare for America, Veterans Affairs, the Department of Defense, and the Coast Guard.

''(D) AUTHORIZATION FOR SECRETARY TO PROCURE DRUGS DIRECTLY.—

''(i) IN GENERAL.—The Secretary may procure a drug manufactured pursu-

ant to a competitive license under subparagraph (A) for purposes of this part or pursuant to a Federal program license under subparagraph (C)(ii) for purposes of a Federal program directly from the entity manufacturing the drug pursuant to such a license.

''(ii) CLARIFICATION REGARDING APPLICATION OF BUY AMERICAN ACT.—In the case where the Secretary procures a drug under this subparagraph, the provisions of chapter 83 of title 41, United States Code (commonly referred to as the 'Buy American Act'), shall apply.

''(E) PRIORITY FOR U.S. MANUFACTURERS IN AUTHORIZING COMPETITIVE LICENSES.—In authorizing a competitive license under this paragraph, the Secretary—

''(i) shall give preference to entities that the Secretary determines have the highest safety and security standards; and

''(ii) may give priority to entities that will manufacture such drug in the United States.

''(4) FDA REVIEW OF LICENSED DRUG APPLICATIONS.—The Secretary shall prioritize review of applications under section 505(j) of the Federal Food, Drug, and Cosmetic Act for drugs licensed under paragraph (3)(A).

''(5) PROHIBITION OF ANTICOMPETITIVE BEHAVIOR.—No drug manufacturer may engage in anticompetitive behavior with another manufacturer that may interfere with the issuance and implementation of a competitive license or run contrary to public policy.

''(6) REQUIRED REPORTING.—The Secretary may require pharmaceutical manufacturers to disclose to the Secretary such information that the Secretary determines necessary for purposes of carrying out this subsection.

''(7) CLARIFICATION.—Nothing in this subsection shall be construed as preventing Medicare for America obtaining a discount or reduction of the price for a covered drug below the price negotiated by the Secretary.

''(8) VALUE OR COST-EFFECTIVENESS ASSESSMENTS.—The use of Quality-Adjusted Life Years, Disability-Adjusted Life Years, or other similar mechanisms is prohibited for use in value or cost-ef-

fectiveness assessments for purposes of this subsection.

''(9) CLARIFICATION.—There shall be no formulary under Medicare for America.

"SEC. 2207. TRUST FUND; FUNDING.

''(a) TRUST FUND.—There shall be established a unified Medicare Trust Fund in which funds provided under this title are deposited and from which expenditures under this title are made. The Trust Fund shall consist of such gifts and bequests as may be made and such amounts as may be deposited in, or appropriated to, such Trust Fund as provided in this Act.

''(b) FUNDING.—

''(1) TAXES.—There are hereby appropriated to the Trust Fund for each fiscal year beginning with fiscal year 2023, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 percent of the net increase in revenues to the Treasury which is attributable to the amendments made by title II of the Medicare for America Act and premiums collected under this title. The amounts appropriated by the preceding sentence shall be transferred from time to time (but not less frequently than monthly) from the general fund in the Treasury to the Trust Fund, such amounts to be

determined on the basis of estimates by the Secretary of the Treasury of the taxes paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the amounts that should have been so transferred.

''(2) CURRENT PROGRAM RECEIPTS.—Notwithstanding any other provision of law, there are hereby appropriated to the Trust Fund for each fiscal year, beginning with fiscal year 2023, the amounts that would otherwise have been appropriated to carry out the following programs:

''(A) The Medicare program under title XVIII.

''(B) The Medicaid program under title XIX, beginning as of 2027.

''(3) ADDITIONAL APPROPRIATIONS.—Additional sums are authorized to be appropriated annually as needed to maintain maximum quality, efficiency, and access under this part.

''(4) MEDICAID MAINTENANCE OF EFFORT PAYMENTS.—There shall be transferred to the Trust Fund the maintenance of effort payments made under section 2209.

''(c) RESTRICTIONS SHALL NOT APPLY.—Any other provision of law in effect on the date of enactment of this title restricting the use of Federal funds for any reproductive health service, including abortion, shall not apply to monies in the Trust Fund.

''(d) INCORPORATION OF PROVISIONS.—The provisions of subsections (b) through (i) of section 1817 shall apply to the Trust Fund under this section in the same manner as such provisions applied to the Federal Hospital Insurance Trust Fund under such section 1817, except that, for purposes of applying such subsections to this section, the 'Board of Trustees of the Trust Fund' shall mean the 'Secretary'.

''(e) TRANSFER OF FUNDS.—Any amounts remaining in the Federal Hospital Insurance Trust Fund under section 1817 or the Federal Supplementary Medical Insurance Trust Fund under section 1841 after the payment of claims for items and services furnished under title XVIII have been completed, shall be transferred into the Trust Fund under this section.

''SEC. 2208. ADMINISTRATIVE PROVISIONS.

''(a) CENTER FOR HEALTH CARE.—Beginning 2023, the Centers for Medicare & Medicaid Services shall be renamed the Center for Health Care and all references in law and regulation to such Centers shall be deemed a ref-

erence to such Center. All powers, duties, and responsibilities of the Centers for Medicare & Medicaid Services shall be transferred to the Center for Health Care.

''(b) AUTHORITY.—The Secretary shall have the authority to issue interim final rules with respect to any provision in this part.

''(c) ADMINISTRATIVE LAW JUDGES.—

''(1) IN GENERAL.—The Center for Health Care is not authorized to appoint administrative law judges, in accordance with pages 11420 through 11499 of title 70 of the Federal Register (March 8, 2005).

''(2) TIMING.—Under this title, administrative law judges must issue a decision within 90 days of receipt of a hearing request, as specified in subsections (a) and (c) of section 405.1016 of title 2, Code of Federal Regulations.

''(d) COVERAGE DETERMINATIONS APPEALS.—

''(1) Individuals may appeal a coverage determination under this title before the individual obtains the service or item that is the subject of the appeal. Individuals shall continue to receive the service or item if an appeal is filed before the provision of the service or item is terminated.

''(2) The Secretary shall eliminate the redetermination by a Medicare administrative contractor from the appeals process under the Medicare program for beneficiaries.

''(e) PRIVATE RIGHT OF ACTION.—

''(1) IN GENERAL.—An applicant or recipient denied a right conferred by this title may bring a civil action seeking any remedy available in law or equity to remedy that violation. State courts and district courts of the United States shall have concurrent jurisdiction of such actions.

''(2) RIGHT DEFINED.—Rights are created by any provision of this title that—

''(A) prescribes, establishes, or confers a benefit or protection in favor of the individual or individuals seeking to enforce the provision; or

''(B) prescribes, establishes, or imposes a duty or obligation on a person or entity to act or conduct operations in a manner that benefits the individual or individuals seeking to enforce the provision.

''(3) REASONABLE ATTORNEY FEES.—In any action or proceeding to enforce this title, the court may award reasonable attorneys' fees and litigation

costs (including expert fees) reasonably incurred against the defendant or defendants.

''(4) APPEAL.—Any civil action brought under this section shall be subject to appeal as provided in sections 1291 and 1292 of title 28 of the United States Code.

''(5) CONTINUED APPLICATION OF OTHER LAWS.—Nothing in this title (or an amendment made by this title) shall be construed to invalidate or limit the rights, remedies, procedures, or legal standards available to individuals aggrieved under section 1979 of the Revised Statutes (42 U.S.C. 1983), or to supersede State laws causes of action.

''(f) NON-DISCRIMINATION.—

''(1) IN GENERAL.—Except as otherwise provided for in this title, an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), or section 1557 of the Affordable Care Act (42 U.S.C. 18116), be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any

health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments) or any employer-sponsored insurance. The enforcement mechanisms provided for and available under such title VI, title IX, section 794, Age Discrimination Act, or such section 1557 shall apply for purposes of violations of this subsection.

''(2) CONTINUED APPLICATION OF LAWS.—Nothing in this title (or an amendment made by this title) shall be construed to invalidate or limit the rights, remedies, procedures, or legal standards available to individuals aggrieved under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), the Age Discrimination Act of 1975 (42 U.S.C. 611 et seq.), or section 1557 of the Affordable Care Act (42 U.S.C. 18116) or to supersede State laws that provide additional protections

against discrimination on any basis described in paragraph (1).

''(3) HEALTH CARE PROVIDERS.—Health care providers may not be prohibited from participating in the Medicare for America for reasons other than their ability to provide covered services. Health care providers and institutions are prohibited from denying covered individuals access to covered benefits and services because of their religious objections. This subsection supercedes any provision of law that allows for conscience protection.

''(4) REGULATIONS.—The Secretary may promulgate regulations to implement this subsection.

''SEC. 2209. MAINTENANCE OF EFFORT REQUIREMENT.

''(a) IN GENERAL.—A State is not eligible for payment under any program specified in subsection (c) for a calendar quarter in a plan year beginning after 2027 unless the State makes to the Secretary for transfer to the unified Medicare Trust Fund under section 2207 the maintenance of effort payment applicable to such State and plan year under subsection (b). The Secretary shall extend such a waiver (including the availability of Federal financial participation under such waiver) for such period as may be required for a State to meet the requirement of the previous sentence.

''(b) MAINTENANCE OF EFFORT PAYMENTS.—For purposes of this section, a maintenance of effort payment with respect to a State and plan year is—

''(1) for plan year 2028 and a State, a payment in an amount equal to the total amount of expenditures of the State for medical assistance under title XIX and child health assistance under title XXI including administrative costs for the plan year before the date of the enactment of this title;

''(2) for plan year 2029 and each subsequent plan year before plan year 2033—

''(A) in the case of a State that is a PPACA expansion State, the payment amount applied under this subsection for the previous plan year, increased by growth in GDP per capita plus 0.4 percent; and

''(B) in the case of a State that is not a PPACA expansion State, the payment amount applied under this subsection for the previous plan year, increased by growth in GDP per capita plus 0.7 percent; and

''(3) beginning in 2033, for each subsequent plan year, with respect to any State, the payment amount applied under this subsection for the pre-

vious year, increased by growth in GDP per capita plus 0.7 percent.

''(c) PROGRAMS SPECIFIED.—For purposes of this section, the programs specified in this subsection are each of the following:

''(1) Block grants for community mental health services under subpart I of part B of title XIX of the Public Health Service Act.

''(2) Block grants and programs for social services and elder justice under title XX.

''(3) Maternal and child health services block grants under title V.

''(4) Block grants for prevention and treatment of substance abuse under subpart II of part B of title XIX of the Public Health Service Act.

''(5) State Targeted Response to Opioid Crisis Grant Community Services Block Grant.

''(6) Grants under section 330 of the Public Health Service Act.

''(7) Ryan White HIV/AIDS Program grants under title XXVI of the Public Health Service Act.

''SEC. 2210. APPLICATION OF TITLE XVIII PROVISIONS.

''Except as specified otherwise in this title, in implementing Medicare for America, the Secretary shall to the greatest extent practicable apply the following provisions

of title XVIII to the program under this title, benefits covered under this title, individuals entitled to benefits under this title, and providers of services and suppliers participating under the program under this title in a similar manner as such provisions applied to the program under title XVIII, benefits covered under such title, individuals entitled to benefits or enrolled under such title, and providers of services and suppliers participating under the program under such title:

''(1) Section 1801.

''(2) Section 1805.

''(3) Section 1806.

''(4) Section 1807.

''(5) Section 1809.

''(6) Section 1814.

''(7) Section 1815.

''(8) Section 1816.

''(9) Section 1818.

''(10) Section 1818A.

''(11) Section 1819.

''(12) Section 1820.

''(13) Section 1834.

''(14) Section 1834A.

''(15) Section 1843.

''(16) Section 1846.

‘‘(17) Section 1847.

‘‘(18) Section 1851.

‘‘(19) Section 1852.

‘‘(20) Section 1855.

‘‘(21) Section 1856.

‘‘(22) Section 1857.

‘‘(23) Section 1858.

‘‘(24) Section 1861.

‘‘(25) Section 1863.

‘‘(26) Section 1864.

‘‘(27) Section 1866B.

‘‘(28) Section 1866C.

‘‘(29) Section 1866E.

‘‘(30) Section 1867.

‘‘(31) Section 1868.

‘‘(32) Section 1869.

‘‘(33) Section 1871.

‘‘(34) Section 1874A.

‘‘(35) Section 1880.

‘‘(36) Section 1881.

‘‘(37) Section 1881A.

‘‘(38) Section 1891.

‘‘(39) Section 1894.

‘‘(40) Section 1895.

‘‘(41) Section 1896.

"PART B—HOME AND COMMUNITY BASED LONG-TERM SERVICES AND SUPPORTS

"SEC. 2231. HOME AND COMMUNITY BASED LONG-TERM SERVICES AND SUPPORTS BENEFIT.

''All individuals enrolled under Medicare for America under this title shall have coverage for home and community based long-term services and supports benefits. Nothing in this part shall be construed to limit an enrollee's entitlement to any other benefit that is covered pursuant to section 2203, including nursing facility benefits.

"SEC. 2232. ELIGIBILITY.

''(a) ELIGIBLE INDIVIDUALS.—An individual who is eligible for home and community based long-term services and supports benefits under this part is an individual who satisfies each of the following:

''(1) The individual is eligible for Medicare for America.

''(2) The individual is determined by a licensed health care practitioner to be unable to perform, without substantial assistance, at least one Activity of Daily Living as described in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986, or to require substantial assistance with one or more of the following areas:

''(A) Communication.

''(B) Social interaction.

''(C) Learning.

''(D) Self-care.

''(E) Self-management.

''(F) Impairments that affect the person's capacity for social or economic participation.

''(b) CLARIFICATION.—Under this part, in the case of an individual described in subsection (a) who experiences periods in which their functional capacity changes or improves, such individual shall continue to have access to benefits under this part as needed. If such an individual's functional capacity improves to a point in which the individual no longer requires home and community based long-term services and supports, or requires fewer services, the individual shall be able to immediately and seamlessly resume receiving all needed services if and when their functional needs recur. Eligibility for services shall be maintained if, without the services, the individual would have reduced functional capacity. When assessing functional impairment, the individual will be assessed without regard to any current services or the ameliorative effects of other mitigating measures described in section 3(4)(E)(i)(I) of the Americans With Disabilities Act of 1990.

''(c) BENEFITS.—

''(1) DEFINITION.—For purposes of this title, the term 'home and community based long-term services and supports benefit' means the daily living supports needed by eligible individuals in order to live, work, and participate in their communities, and includes all home and community based services and supports coverable as of the date of the enactment of this title, under any State plan or waiver under title XIX, including—

''(A) home health aides and homemakers;

''(B) direct support professionals and personal attendant care services;

''(C) hospice;

''(D) nursing care;

''(E) medical social services;

''(F) care coordination, including case management, fiscal intermediary, and support brokerage services;

''(G) short-term inpatient care, including respite care and care for pain control;

''(H) behavioral health home and community based long-term services and supports, including assertive community treatment; peer support services; intensive care coordination, in-

cluding case management; supported employment; and supported housing wraparound;

''(I) private-duty nursing;

''(J) respite services provided in the individual's home or broader community; and

''(K) transitional services to support an individual's transition from an institutional setting to the community.

''(2) NON-APPLICATION.—The provisions of sections 424.22(a)(1)(i) and 424.22(a)(1)(ii) of title 42 of the Code of Federal Regulations does not apply in the case of the benefit described in paragraph (1)(A).

''(d) HOME AND COMMUNITY BASED LONG-TERM SERVICES AND SUPPORTS WORKFORCE DEVELOPMENT.—

''(1) IN GENERAL.—The Secretary shall ensure that the number of individuals in the home and community based long-term services and supports workforce is adequate to ensure community integration for all beneficiaries under Medicare for America. In so doing, the Secretary may consider a wide range of factors, including payment rates for direct care workers, career pipelines and credentialing, worker rights, and the impact of national labor policies.

''(2) SELF-DIRECTED MODEL.—All eligible individuals shall be defaulted into a self-directed care option (as defined by the Secretary). The Secretary must consult with eligible individuals, caregivers, workers and their representatives, including unions, and state entities responsible for administering the LTSS benefit to establish this model.

''(3) COMMUNITY FIRST.—The benefit under this part shall be arranged for and provided with a community first presumption and eligible individuals shall be provided home and community based long-term services and support available under this section, regardless of type or level of disability or service need. No eligible individual may be referred to an institution without first being offered and, if chosen, provided home and community based long-term services and supports. Individuals in an institution on the effective date of the bill, and at least annually or upon any change in condition thereafter, shall be informed of, and if chosen, provided with home and community based long-term services and supports.

''(e) ADMINISTRATION OF SERVICES AND SUPPORTS.—State entities responsible for administering home and community based long-term services and support benefits under any State plan or waiver under title XIX as

of the date of the enactment of this title shall continue to administer the benefits and services coverable under this section.

''(f) COORDINATION WITH OTHER FEDERAL BENEFITS.—

''(1) RULE OF CONSTRUCTION.—Nothing in this part shall be construed as prohibiting benefits paid under this part from being used to compensate a caregiver who provides community living assistance services and supports to a dependent relative for providing community living assistance services and supports to an eligible individual under this part.

''(2) DEPENDENT RELATIVE DEFINED.—The term 'dependent relative' means a child, grandchild, niece, nephew, parent, grandparent, sibling, aunt, or uncle (of such caregiver or his or her spouse or domestic partner); such caregiver's spouse or domestic partner, if such child, grandchild, niece, nephew, parent, grandparent, sibling, aunt, uncle, spouse, or domestic partner is an eligible individual.

''(3) SUPPLEMENT NOT SUPPLANT.—Benefits received under this part by a caregiver shall supplement, but not supplant, other benefits for which the individual is eligible under any other federally funded program that provides benefits or assistance.

''(4) DISREGARD.—The benefit paid under this part shall be disregarded for purposes of determining or continuing the eligibility of the individual or the spouse of the individual for receipt of benefits under any other Federal, State, or locally funded assistance program, including benefits paid under title II or XVI, under the laws administered by the Secretary of Veterans Affairs, under low-income housing assistance programs, under the supplemental nutrition assistance program established under the Food and Nutrition Act of 2008, or under programs administered by State vocational rehabilitation agencies.

''(5) REGULATIONS.—Not later than one year after the date of the enactment of this section, the Secretary shall promulgate such regulations as are necessary to carry out this part and to prevent fraud and abuse with respect to the benefits under this part.

"PART C—MEDICARE ADVANTAGE FOR AMERICA

"SEC. 2221. ALL PRIVATE PLANS.

''(a) IN GENERAL.—For plan years beginning with plan year 2023, a health insurance issuer may offer health insurance coverage in the individual market only if such

issuer has entered into a contract with the Secretary under subsection (b) to offer such coverage.

''(b) AGREEMENTS.—The Secretary shall enter into an agreement with an MA for America sponsor to offer MA for America plans under this part for the coverage of individuals enrolled under Medicare for America who elect to receive benefits under part A through such a plan.

''(c) MA FOR AMERICA PLAN; MA FOR AMERICA SPONSOR.—For purposes of this part:

''(1) MA FOR AMERICA PLAN.—An MA for America plan is a Medicare Advantage plan under part C of title XVIII, except such plan shall provide coverage for individuals enrolled under Medicare for America under part A of this title, with respect to at least the benefits covered under such part A.

''(2) MA FOR AMERICA SPONSOR.—An MA for America sponsor is a sponsor of an MA for America plan.

''SEC. 2222. APPLICATION OF MEDICARE ADVANTAGE PROVISIONS.

''For purposes of applying this part, except as otherwise specified under this part, the provisions of part C of title XVIII, as in effect as of the date of the enactment of this title shall apply with respect to an MA for America sponsor, MA for America plan, individuals eligible for cov-

erage under this part, individuals enrolled under such plan, and benefits covered under part A in a similar manner and to a similar extent as such provisions applied to an MA organization, MA plan, individuals eligible for under part C of such title, individuals enrolled under an MA plan, and benefits covered under fee-for-service Medicare as of such date.

"SEC. 2223. MEDICARE ADVANTAGE FOR AMERICA PAYMENT RATES.

''The rates for Medicare Advantage for America plans shall be equal to the rates paid by Medicare for America. The Administrator of the Center for Healthcare shall pay Medicare Advantage for America plans 95 percent of average Medicare for America costs in each county.

"SEC. 2224. SEPARATE PREMIUM FOR MEDICARE ADVANTAGE FOR AMERICA PLANS FURNISHING SUPPLEMENTAL BENEFITS.

''Nothing in this part shall preclude an individual from choosing a Medicare Advantage for America plan which requires the individual to pay an additional, separate amount because of supplemental benefits or because it is a more expensive plan. In such case the individual enrolled under such plan would be responsible for a separate monthly premium.

"SEC. 2225. PRESCRIPTION DRUG PRICING UNDER MEDICARE ADVANTAGE FOR AMERICA PLANS.

''Medicare Advantage for America plans, for prescription drugs, shall pay no more than the price negotiated under Medicare for America.

"SEC. 2226. BAN ON PAYING BROKERS' FEES.

''Medicare Advantage for America plans may not pay fees to insurance brokers.

"SEC. 2227. CLARIFICATION ON MEDICARE ADVANTAGE EMPLOYER GROUP WAIVER PLANS AND THE MEDICARE SECONDARY PAYER REQUIREMENT.

''Such plans shall be exempt from the MSP Requirement, and nothing in this section shall be construed as prohibiting such plans from contributing to the payment of premiums and cost-sharing.

"SEC. 2228. REFERENCES.

''Beginning in 2023, all references in law and regulation to Medicare Advantage shall be deemed a reference to Medicare Advantage for America.''.

SEC. 112. MODIFICATIONS TO AND COORDINATION WITH EXISTING FEDERAL HEALTH PROGRAMS.

(a) MEDICARE, MEDICAID, AND STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP).—

(1) IN GENERAL.—Notwithstanding any other provision of law, subject to paragraphs (2) and (3)

and section 2202(c) of the Social Security Act, as added by section 111—

(A) no benefits shall be available under title XVIII of the Social Security Act for any item or service furnished—

(i) beginning on or after January 1, 2023 (except in the case of an individual enrolled under such title and title XIX of such Act); and

(ii) beginning on or after January 1, 2025, with respect to all individuals, including individuals enrolled under such title and title XIX of such Act;

(B) no individual is entitled to medical assistance under a State plan approved under title XIX of such Act—

(i) for any item or service furnished on or after January 1, 2025, in the case of an individual enrolled under such title and title XVIII of the Social Security Act or an individual described in subclause (VIII) of section 1902(a)(10)(A)(i); and

(ii) for any item or service furnished on or after January 1, 2027;

(C) no individual is entitled to medical assistance under a State child health plan under title XXI of such Act for any item or service furnished on or after January 1, 2025; and

(D) no payment shall be made to a State under section 1903(a) or 2105(a) of such Act with respect to medical assistance or child health assistance—

(i) for any item or service furnished on or after January 1, 2025, in the case of an individual enrolled under such title and title XVIII of the Social Security Act or an individual described in subclause (VIII) of section 1902(a)(10)(A)(i); and

(ii) for any item or service furnished on or after January 1, 2027.

(2) TRANSITION.—In the case of inpatient hospital services and extended care services during a continuous period of stay which began before January 1, 2025, for Medicare and 2027 for Medicaid or CHIP, and which had not ended as of such date, for which benefits are provided under title XVIII of the Social Security Act, under a State plan under title XIX of such Act, or under a State child health plan under title XXI such Act, the Secretary of Health

and Human Services shall provide for continuation of benefits under such title or plan until the end of the period of stay.

(b) OTHER FEDERAL HEALTH PROGRAMS.—

(1) FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM.—Nothing in this Act, or the amendments made by this Act, shall affect benefits made available under chapter 89 of title 5, United States Code.

(2) TRICARE.—Nothing in this Act, or the amendments made by this Act, shall affect benefits made available under sections 1079 and 1086 of title 10, United States Code.

(3) TREATMENT OF BENEFITS FOR VETERANS AND NATIVE AMERICANS.—

(A) IN GENERAL.—Nothing in this Act, or the amendments made by this Act, shall affect the eligibility of veterans for the medical benefits and services provided under title 38, United States Code, or of Indians for the medical benefits and services provided by or through the Indian Health Service.

(B) REEVALUATION.—No reevaluation of the Indian Health Service shall be undertaken without consultation with tribal leaders and stakeholders.

(C) SUPPLEMENTAL INDIAN HEALTH SERVICES ALLOCATION.—The Secretary shall annually determine the need to provide an allotment of supplemental funds to Indian Health Services, including payments to providers, health professional education, administrative expenses, and prevention and public health activities.

(4) ENROLLEE CHOICE.—Nothing in this Act shall preclude individuals enrolled in the Federal Employees Health Benefits Program or TRICARE or individuals receiving benefits provided under title, 38, United States Code or the Indian Health Service from enrolling in Medicare for America. Enrollees shall be entitled to the employer contribution as established under section 126(c) of such Act.

(c) SUNSET OF PROVISIONS RELATED TO THE STATE EXCHANGES.—Effective January 1, 2022, the Federal and State Exchanges established pursuant to title I of the Patient Protection and Affordable Care Act (Public Law 111–148) shall terminate, and any other provision of law that relies upon participation in or enrollment through such an Exchange, including such provisions of the Internal Revenue Code of 1986, shall cease to have force or effect.

(d) SEVERABILITY.—Every provision in this Act and every application of the provisions in this Act are severable from each other as a matter of Federal law. If any application of any provision in this Act to any person or group of persons or circumstances is found by a court to be invalid, the remainder of this Act and the application of the Act's provisions to all other persons and circumstances may not be affected.

Subtitle C—Targeted Reforms

SEC. 121. NO SURPRISE BILLING.

(a) SURPRISE BILL DEFINED.—For purposes of this section the term ''surprise bill''—

(1) means a bill for health care services, other than emergency services, received by an insured for services rendered by an out-of-network health care provider, where such services were rendered by such out-of-network provider at an in-network facility, during a service or procedure performed by an in-network provider or during a service or procedure previously approved or authorized by the health carrier and the insured did not knowingly elect to obtain such services from such out-of-network provider; and

(2) does not include a bill for health care services received by an insured when an in-network

health care provider was available to render such services and the insured knowingly elected to obtain such services from another health care provider who was out-of-network.

(b) No non-participating health care provider shall require prior authorization for rendering emergency services to an insured.

(c) No health carrier shall impose, for emergency services rendered to an insured by an out-of-network health care provider, a coinsurance, copayment, deductible or other out-of-pocket expense that is greater than the coinsurance, copayment, deductible or other out-of-pocket expense that would be imposed if such emergency services were rendered by an in-network health care provider.

(d) PAYMENT AMOUNT.—If emergency services were rendered to an insured by an out-of-network health care provider, such health care provider may bill the health carrier directly and the health carrier shall reimburse such health care provider the greatest of the following amounts:

(1) The amount payable under Medicare for America for such services if rendered by a health care provider participating in Medicare for America.

(2) The arbitrated amount between the qualifying health plan and the non-participating provider.

(e) Nothing in this section shall be construed to prohibit the qualifying health plan and the non-participating health care provider from agreeing to a greater reimbursement amount.

(f) NON-EMERGENCY SERVICES.—With respect to a surprise bill, the following applies:

(1) An individual enrolled in the qualifying health plan shall only be required to pay the applicable coinsurance that would be imposed for such health care services if such services were rendered by a participating health care provider.

(2) The qualifying health plan shall reimburse the non-participating health care provider or individual enrolled in such health plan, as applicable, for health care services rendered at the qualifying health plane rate as payment in full, unless the health plan and the non-participating health care provider agree otherwise.

(g) If health care services were rendered to an individual enrolled in qualifying health coverage by a non-participating health care provider and the qualifying health plan failed to inform such enrollee, if such enrollee was required to be informed, of the network status of such non-participating health care provider, the qualifying health plan shall not impose coinsurance expense that is

greater than the maximum out-of-pocket expense that would be imposed if such services were rendered by a qualifying health care provider.

(h) EMERGENCY SERVICES.—

(1) NO PRIOR AUTHORIZATION.—A health care provider not participating in Medicare for America may not require prior authorization for rendering emergency services to an individual enrolled under Medicare for America.

(2) OUT-OF-POCKET EXPENSES.—A health care provider not participating in Medicare for America may not impose, for emergency services rendered to an individual enrolled in Medicare for America, a coinsurance, copayment, or other out-of-pocket expense that is greater than the coinsurance or maximum out-of-pocket expense that would be imposed if such emergency services were rendered by a Medicare for America participating provider.

(3) PAYMENT AMOUNT.—If emergency services are rendered to an individual enrolled in Medicare for America by a health care provider not participating in Medicare for America, such health care provider may bill Medicare for America directly and Medicare for America shall reimburse such health care provider the greatest of the following amounts:

(A) The amount payable under Medicare for America for such services if rendered by a health care provider participating in Medicare for America.

(B) The arbitrated amount between the Secretary of Health and Human Services and the provider, determined by an arbitration process established by the Secretary.

(i) NON-EMERGENCY SERVICES.—With respect to a surprise bill, the following applies:

(1) An individual enrolled in qualifying coverage (as defined in section 2202(b)(4)(B) of the Social Security Act) shall only be required to pay the applicable coinsurance that would be imposed for such health care services if such services were rendered by a health care provider participating in Medicare for America.

(2) The Secretary of Health and Human Services shall reimburse the non-participating health care provider or individual enrolled in such health plan, as applicable, for health care services rendered at rate payable under Medicare for America as payment in full, unless the Secretary and the non-participating health care provider agree otherwise.

(3) If health care services were rendered to an individual enrolled in Medicare for America by a health care provider not participating in Medicare for America and the Secretary of Health and Human Services failed to inform such enrollee, if such enrollee was required to be informed, of the network status of such non-participating health care provider, the Secretary shall not impose a coinsurance expense that is greater than the maximum out-of-pocket expense that would be imposed if such services were rendered by a provider participating in Medicare for America.

SEC. 122. LIMITATION ON REMOVAL OF MEDICARE ADVANTAGE PROVIDERS BY MA ORGANIZATIONS.

(a) LIMITATION.—Section 1852(d) of the Social Security Act (42 U.S.C. 1395w–22(d)) is amended by adding at the end the following:

''(7) LIMITATION ON REMOVAL OF PROVIDERS FROM MA PLANS BY MA ORGANIZATIONS.—

''(A) REMOVAL OF PROVIDERS WITH CAUSE.—Beginning with plan year 2020, except as provided in subparagraph (C), an MA organization offering an MA plan may only remove a provider of services or a supplier from a net-

work of such plan if the organization has cause to remove such provider or supplier.

''(B) CAUSE TO REMOVE PROVIDERS.—

''(i) IN GENERAL.—An MA organization offering an MA plan has cause to remove a provider of services or a supplier from a network of such plan if the Secretary determines that the provider or supplier is—

''(I) medically negligent;

''(II) in violation of any legal or contractual requirement applicable to the provider or supplier acting within the lawful scope of practice, including any participation or other requirement applicable to such provider or supplier under this title or under any contractual term for such plan; or

''(III) otherwise unfit to furnish items and services in accordance with requirements of this title.

''(ii) CONSIDERATION OF COST TO MA ORGANIZATIONS.—For purposes of subparagraph (A), cost to an MA organization offering an MA plan due to the participa-

tion of a provider of services or supplier in a network of such plan does not constitute cause for the MA organization to remove such provider or supplier from the network mid-year, and such cost may not be considered as a factor in favor of a determination that such organization has cause to remove the provider.

''(C) EXCEPTION.—With respect to each upcoming plan year, beginning with plan year 2020 an MA organization offering an MA plan may only remove a provider of services or supplier from a network of such plan for reasons not specified in subparagraph (B)(i) before the date that is 60 days before the first day of the annual coordinated election period for such plan year under section 1851(e)(3).

''(D) NOTICE AND APPEAL PROCESS.—

''(i) IN GENERAL.—Any removal of a provider of services or supplier from a network of an MA plan may occur only after the completion of a fair notice and appeal process that the Secretary shall establish by regulation. Such process shall require the MA organization to provide to such

provider or supplier and to the Secretary an explanation of the reason or reasons for the removal. The Secretary shall make this information publicly available.

"(ii) APPLICATION.—

"(I) APPLICATION OF NEW PROCESS.—In the case of a removal of a provider of services or supplier from a network of an MA plan occurring on or after the effective date published in a final rule for such fair notice and appeal process, such process shall apply in lieu of the process for the termination or suspension of a provider contract under section 422.202(a) of title 42, Code of Federal Regulations.

"(II) CONTINUATION OF OLD PROCESS.—In the case of a removal of a provider of services or supplier from a network of an MA plan occurring before such effective date, the process for the termination or suspension of a provider contract under section

422.202(a) of title 42, Code of Federal Regulations, shall apply.

''(E) PARTICIPANT NOTICE AND PROTECTION.—

''(i) NOTICE TO PARTICIPANTS OF PROVIDER REMOVAL.—Not less than 60 days before the date on which a provider of services or supplier is removed from a network of an MA plan, the MA organization offering such plan shall provide written notification of the removal to each individual enrolled in such plan receiving items or services from the provider or supplier during the plan year in effect on the date of removal or during the previous plan year. Such notification shall include at the minimum—

''(I) the names and telephone numbers of available in-network providers of services and suppliers offering items and services that are the same or similar to the items and services offered by the removed provider or supplier;

''(II) information regarding the options available to an individual enrolled in such plan to request the continuation of medical treatment or therapy with the removed provider or supplier; and

''(III) one or more customer service telephone numbers that an individual enrolled in such plan may access to obtain information regarding changes to the network of the plan.

''(ii) ANNUAL NOTICE OF CHANGE.—In addition to providing the notification of removal as required under clause (i), the MA organization offering such MA plan shall include such notification in the annual notice of change for the MA plan for the upcoming plan year.

''(iii) CONTINUITY OF CARE.—In any case in which a provider of services or supplier is removed from a network of an MA plan, such plan shall ensure that the removal satisfies the continuity of care requirements under paragraph (1)(A) with respect to each individual enrolled in such

plan receiving items or services from the provider or supplier during the plan year in effect on the date of removal or during the previous plan year.

''(F) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as affecting the ability of a provider of services or supplier to decline to participate in a network of an MA plan.

''(8) TRANSPARENCY IN MEASURES USED BY MA ORGANIZATIONS TO ESTABLISH OR MODIFY PROVIDER NETWORKS.—

''(A) IN GENERAL.—Beginning with plan year 2020, an MA organization offering an MA plan shall publish and make accessible the information described in subparagraph (B)—

''(i) in the annual bid information submitted by the MA organization with respect to the MA plan under section 1854; and

''(ii) on the Internet Web Site for the MA plan.

''(B) INFORMATION DESCRIBED.—The information described in this subparagraph is the following:

''(i) Information regarding the measures used by the MA organization to establish or modify the provider network of the MA plan, including measures of the quality and efficiency of providers. Such information shall include the specifications, methodology, and sample size of such measures.

''(ii) Other information related to the establishment or modification of such provider network that the Secretary determines appropriate.

''(C) LIMITATION.—The information described in subparagraph (B) shall not include any individually identifiable information of any provider or supplier of services.''.

(b) ENFORCEMENT.—

(1) SANCTIONS FOR NONCOMPLIANCE.—Section 1857(g)(1) of the Social Security Act (42 U.S.C. 1395w–27(g)(1)) is amended—

(A) in subparagraph (J), by striking ''or'';

(B) by redesignating subparagraph (K) as subparagraph (L);

(C) by inserting after subparagraph (J) the following new subparagraph:

''(K) fails to comply with section 1852(d)(7) or 1852(d)(8); or''; and

(D) in subparagraph (L) (as so redesignated), by striking ''through (J)'' and inserting ''through (K)''.

(2) SANCTIONS NOT APPLICABLE TO PART D.—Title XVIII of the Social Security Act is amended—

(A) in section 1860D–12(b)(3)(E) (42 U.S.C. 1395w–112(b)(3)(E)), by striking ''paragraph (1)(F)'' and inserting ''paragraphs (1)(F) and (1)(K)''; and

(B) in section 1894(e)(6)(B) (42 U.S.C. 1395eee(e)(6)(B)), by inserting ''(other than paragraph (1)(K) of such section)'' after ''1857(g)(1)''.

(c) MEDICARE ADVANTAGE PLAN COMPARE TOOL.—Not later than one year after the date of enactment of this Act, the Secretary of Health and Human Services shall take such measures as are necessary to ensure that the Medicare Advantage Compare Tool takes into account the preferences and utilization needs of such individuals.

SEC. 123. NETWORK ADEQUACY.

(a) IN GENERAL.—Section 1852(d) of the Social Security Act (42 U.S.C. 1395w–22(d)) is amended by adding at the end the following:

''(9) NETWORK ADEQUACY REQUIREMENTS.—Beginning in plan year 2019, notwithstanding any other provision of law, the following shall apply:

''(A) PROVIDER AVAILABILITY.—When establishing a plan network, a Medicare Advantage organization offering an MA plan shall, among other factors determined by the Secretary, consider the following:

''(i) The anticipated enrollment in the plan.

''(ii) The expected types of services provided and utilization of services by enrollees under the plan.

''(iii) The number and types of providers needed to provide such services.

''(iv) The number of network providers who are not accepting new patients.

''(v) The location of providers and enrollees, taking into account geographic disbursement.

''(vi) The full-time equivalent availability of a provider to provide such services.

''(B) PROVISION OF CARE IN A TIMELY MANNER.—A Medicare Advantage organization

offering an MA plan shall ensure that providers are able to provide services in a timely manner, as defined by the Secretary, under the plan.

''(C) APPLICATION OF NETWORK ACCESS ADEQUACY STANDARDS.—In applying the network access adequacy standards pursuant to paragraph (1), the Secretary shall seek input from patient advocacy groups, providers of services and suppliers, and MA plans under this part.

''(D) CERTIFICATION.—Each plan year, a Medicare Advantage organization shall certify to the Secretary, with respect to each MA plan offered by the organization, that the providers, including specialists and subspecialists, in the plan network are able to provide the services required under the organization's contract with the Secretary under section 1857 with respect to the offering of such plan and to meet the needs of the enrollees within the plan service area during the year.

''(E) ANNUAL REPORTING.—Each plan year, a Medicare Advantage organization shall report to the Secretary, and make public the

following with respect to each MA plan offered by the organization:

"(i) AVERAGE WAIT TIME.—The average wait time for primary and specialty care for enrollees under the plan.

"(ii) UTILIZATION OF OUT OF NETWORK PROVIDERS.—The utilization of out-of-network providers under the plan.

"(iii) AVERAGE COST PER PATIENT.—The average annual spending per patient for primary and specialty care for enrollees under the plan.

"(F) CERTIFICATION.—In advance of the annual, coordinated election period under section 1851(e)(3), a Medicare Advantage organization shall certify to the Secretary the accuracy of provider directories for each plan offered by the organization.

"(G) NETWORK REVIEW.—The Secretary shall ensure that the network of each MA plan offered by a Medicare Advantage organization meets the network adequacy guidelines established under this paragraph and under section 422.112(a)(4) of title 42, Code of Federal Regulations (or any successor regulation to such

section) at least once every 3 years or when a material change in network occurs.

''(H) AUTHORITY.—The Secretary shall have the authority to stop any further enrollment in a Medicare Advantage plan if there is a pattern of excessive violations of this paragraph.''.

(b) ENFORCEMENT.—Section 1857(g)(1)(K) of the Social Security Act (42 U.S.C. 1395w–27(g)(1)(K)), as added by section 2(b), is amended by striking ''or 1852(d)(8)'' and inserting '', 1852(d)(8), or 1852(d)(9)''.

SEC. 124. ELIMINATING THE 24-MONTH WAITING PERIOD FOR MEDICARE COVERAGE FOR INDIVIDUALS WITH DISABILITIES.

(a) IN GENERAL.—Section 226(b) of the Social Security Act (42 U.S.C. 426(b)) is amended—

(1) in paragraph (2)(A), by striking '', and has for 24 calendar months been entitled to,'';

(2) in paragraph (2)(B), by striking '', and has been for not less than 24 months,'';

(3) in paragraph (2)(C)(ii), by striking '', including the requirement that he has been entitled to the specified benefits for 24 months,'';

(4) in the first sentence, by striking ''for each month beginning with the later of (I) July 1973 or

(II) the twenty-fifth month of his entitlement or status as a qualified railroad retirement beneficiary described in paragraph (2), and'' and inserting ''for each month for which the individual meets the requirements of paragraph (2), beginning with the month following the month in which the individual meets the requirements of such paragraph, and''; and

(5) in the second sentence, by striking ''the 'twenty-fifth month of his entitlement' '' and all that follows through ''paragraph (2)(C) and''.

(b) CONFORMING AMENDMENTS.—

(1) SECTION 226.—Section 226 of the Social Security Act (42 U.S.C. 426) is amended by—

(A) striking subsections (e)(1)(B), (f), and (h); and

(B) redesignating subsections (g) and (i) as subsections (f) and (g), respectively.

(2) MEDICARE DESCRIPTION.—Section 1811(2) of the Social Security Act (42 U.S.C. 1395c(2)) is amended by striking ''have been entitled for not less than 24 months'' and inserting ''are entitled''.

(3) MEDICARE COVERAGE.—Section 1837(g)(1) of the Social Security Act (42 U.S.C. 1395p(g)(1))

is amended by striking ''25th month of'' and inserting ''month following the first month of''.

(4) RAILROAD RETIREMENT SYSTEM.—Section 7(d)(2)(ii) of the Railroad Retirement Act of 1974 (45 U.S.C. 231f(d)(2)(ii)) is amended—

(A) by striking ''has been entitled to an annuity'' and inserting ''is entitled to an annuity'';

(B) by striking '', for not less than 24 months''; and

(C) by striking ''could have been entitled for 24 calendar months, and''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to insurance benefits under title XVIII of the Social Security Act with respect to items and services furnished in months beginning after the date of enactment of this Act.

SEC. 125. ELIMINATING THE WAITING PERIOD FOR INDIVIDUALS ON STATE MEDICAID WAITING LISTS.

The Secretary of Health and Human Services is appropriated such sums as are necessary to facilitate enrollment, not later than 90 days after the date of the enactment of this Act, all eligible individuals who, as of the

date of the enactment of this Act, are on State Medicaid waiting lists or State Medicaid waiver waiting lists.

SEC. 126. EMPLOYER HEALTH PLAN OPTIONS.

(a) DEFINITION.—A qualifying employer-sponsored plan is—

(1) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act); or

(2) any other plan or coverage that meets the criteria under subsection (b), includes vision, dental, and hearing benefits, and provides health coverage that is equivalent to an actuarial value of at least 80 percent of the coverage provided under title XXII of the Social Security Act and makes a premium contribution of at least 70 percent.

Such plan shall require a premium contribution from the employer of at least 70 percent regardless of whether coverage is for single, spousal, or dependent care.

(b) OBLIGATION.—Large employers shall, with respect to any full-time employee of such employer—

(1) offer a qualifying employer-sponsored plan to such employee, in accordance with subsection (a); or

(2) make a contribution of 8 percent of their annual payroll to the Medicare Trust Fund under title XXII of the Social Security Act.

(c) EMPLOYEE CHOICE.—An employee may opt out of a qualifying employer-sponsored plan as satisfied by subsection (b)(1) in order to enroll in Medicare for America. The employer shall make a contribution equal to the contribution it shall make in order to meet the requirements established by subsection (a)(1) or (a)(2). The Secretary of Health and Human Services shall have authority to set standards for determining whether employers or insurers are undertaking any actions to affect the risk pool within Medicare for America by inducing individuals to decline coverage under a qualifying employer-sponsored plan and instead to enroll in Medicare for America. An employer violating such standards shall be treated as not meeting the requirements of subsection (a).

(d) EMPLOYEE EDUCATION ON HEALTH COVERAGE OPTIONS.—Large employers shall disseminate to employees such publicly available information on coverage options under Medicare for America as the Secretary deems appropriate, including contact information for assistance.

(e) SPECIAL RULES.—

(1) ANNUAL PAYROLL.—For purposes of this paragraph, the term ''annual payroll'' means, with

respect to any employer for any calendar year, the aggregate wages paid by the employer during such calendar year.

(2) AGGREGATION RULES.—Related employers and predecessors shall be treated as a single employer for purposes of this subsection.

(3) REDUCTION FOR PART-TIME EMPLOYEES.—In the case of a part-time employee, the employer contribution requirements of paragraph (1) shall be treated as satisfied if the employer contribution with respect to such employee is not less than the part-time employment ratio of the contribution required under paragraph (1).

(4) RULES RELATED TO PART-TIME EMPLOYMENT.—For purposes of this subsection—

(A) PART-TIME EMPLOYEE.—The term ''part-time employee'' means, with respect to any month, an employee who works on average fewer than 30 hours per week.

(B) PART-TIME EMPLOYMENT RATIO.—The term ''part-time employment ratio'' means, with respect to a part-time employee of an employer in a month, a fraction—

(i) the numerator of which is the number of hours in the employee's normal work week; and

(ii) the denominator of which is 30 hours.

(C) SPECIAL RULES.—Under rules prescribed by the Secretary of Health and Human Services, in consultation with the Secretary of the Treasury, in the case of an employee for an employer whose defined work week for full-time employees is less than 30 hours, any reference in this subsection to 30 hours is deemed a reference to the number of hours in the work week so defined.

(D) CONVERSION TO HOURS OF EMPLOYMENT.—The Secretary of Health and Human Services, in consultation with the Secretary of the Treasury, shall establish rules for the conversion of compensation to hours of employment, for purposes of this subsection in the case of employees that receive compensation on a salaried basis, or on the basis of a commission, or other contingent or bonus basis, rather than based on an hourly wage.

(f) TIMING AND MANNER.—Each employer that makes a financial contribution under subsection (b)(2) and (c) under this section (other than with respect to coverage under a group health plan) shall pay such contribution in a form and manner, specified by the Secretary of the Treasury, based upon the form and manner in which employer excise taxes are required to be paid under section 3111 of the Internal Revenue Code of 1986.

(g) NON-DISCRIMINATION.—

(1) IN GENERAL.—Except as otherwise provided for in this title (or an amendment made by this title), an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency

or any entity established under this title (or amendments) or any employer-sponsored insurance.

(2) CONTINUED APPLICATION OF LAWS.—Nothing in this title (or an amendment made by this title) shall be construed to invalidate or limit the rights, remedies, procedures, or legal standards available to individuals aggrieved under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), or the Age Discrimination Act of 1975 (42 U.S.C. 611 et seq.), or to supersede State laws that provide additional protections against discrimination on any basis described in paragraph (1).

(3) LIMITATION.—A group health plan may not establish rules relating to the health insurance coverage eligibility (including continued eligibility) or contribution requirements of any full-time employee under the terms of the plan that have the effect of discriminating in favor of higher-wage employees.

(4) REGULATIONS.—The Secretary of Health and Human Services, in conjunction with the Sec-

retary of Labor, may promulgate regulations to implement this subsection.

SEC. 127. PROHIBITION ON STEP THERAPY AND PRIOR AUTHORIZATION UNDER GROUP HEALTH PLANS.

Section 2719A of the Public Health Service Act (42 U.S.C. 300gg–19a) is amended by adding at the end the following new subsection:

''(e) PROHIBITION AGAINST STEP THERAPY AND PRIOR AUTHORIZATION.—Beginning with the first plan year following the date of the enactment of this subsection, a group health plan may not require a prior authorization determination for coverage of any benefit under such plan and may not apply treatment limitations through the use of step therapy protocols.''.

SEC. 128. MEDICARE OUTPATIENT OBSERVATION SERVICES.

Section 1861(i) of the Social Security Act (42 U.S.C. 1395x(i)) is amended by adding at the end the following: ''For purposes of this subsection, an individual receiving outpatient observation services shall be deemed to be an inpatient during such period, and the date such individual ceases receiving such services shall be deemed the hospital discharge date (unless such individual is admitted as a hospital inpatient at the end of such period)''.

SEC. 129. ABORTION COVERAGE.

Notwithstanding any other provision of law, Federal funds may be used to provide for abortion services under any health program or activity.

SEC. 130. APPLICABILITY OF MENTAL HEALTH PARITY.

Section 2726 of the Public Health Service Act shall apply to all health coverage in the same manner and to the same extent as such section applies to health insurance issuers and group health plans under title XXVII of such Act.

SEC. 131. STUDENT LOAN FORGIVENESS FOR HEALTH CARE PROVIDERS PARTICIPATING IN MEDICARE FOR AMERICA.

(a) IN GENERAL.—Beginning on the date after the date of the enactment of this Act, after the conclusion of each plan year, the Secretary of Health and Human Services, in conjunction with the Secretary of Education, shall cancel the applicable percent specified in subsection (b) of the total amount due on any eligible Federal Loan made 20 years prior to date of enactment and any date after the date of enactment of this Act for a borrower who is a Medicare for America participating provider and submits an employment certification form described in subsection (d).

(b) APPLICABLE PERCENT.—For purposes of subsection (a), the applicable percent is 10 percent of any

eligible Federal Loan for each year the health care provider participates in Medicare for America.

(c) DEFINITIONS.—In this section:

(1) ELIGIBLE FEDERAL LOAN.—The term ''eligible Federal loan'' means any loan made under part D of title IV of the Higher Education Act of 1965 (20 U.S.C. 1087a).

(2) HEALTH CARE PROVIDER.—The term ''health care provider'' means a physician, physician assistant, registered nurse, nurse practitioner, advanced practice nurse, licensed practical nurse, psychologist, mental health counselor, marriage and family therapist, direct care worker, health social worker, dentist, dental hygienist, pharmacist, physical therapist, occupational therapist, or any other health care provider specified by the Secretary of Health and Human Services if the Secretary determines such specification for purposes of this section is necessary to ensure workforce adequacy.

(3) MEDICARE FOR AMERICA PARTICIPATING PROVIDER.—The term ''Medicare for America participating provider'' means a health care provider that meets the definition of such term under section 105 or works at a participating provider or entity as defined under section 105.

(d) EMPLOYMENT CERTIFICATION FORM.—

(1) IN GENERAL.—In order to receive loan cancellation under this paragraph, a borrower shall submit to the Secretary of Education an employment certification form that is developed by the Secretary of Education and includes self-certification of employment and a separate part for employer certification that indicates the dates of employment.

(2) DEFERMENT.—If a borrower submits to the Secretary of Education the employment certification form described in paragraph (1), during the period in which the borrower is employed as a Medicare for America participating provider for which loan cancellation is eligible under this section, the borrower's eligible Federal Direct Loan shall be placed in deferment.

(e) INTEREST CANCELED.—If a portion of a loan is canceled under this section for any year, the entire amount of interest on such loan that accrues for such year shall be canceled.

(f) REGULATIONS.—The Secretary of Health and Human Services and Secretary of Education may promulgate regulations to implement this section.

SEC. 132. CLARIFICATION OF THE DEFINITION OF PEDIATRIC MEDICAL NECESSITY IN QUALIFYING GROUP COVERAGE.

(a) DEFINITION.—The following definition of pediatric medical necessity shall be incorporated into benefit standards of all plans subject to the requirements of section 1302 of the Patient Protection and Affordable Care Act (42 U.S.C. 18022) and all group plans by 2023.

(b) DEVELOPMENT OF DEFINITION.—Pediatric medical necessity, or pediatric medically necessary care, shall be defined as health care interventions that are evidence based, evidence informed, or based on consensus advisory opinion and that are recommended by recognized health care professionals, to promote optimal growth and development in a child and to prevent, detect, diagnose, treat, ameliorate, or palliate the effects of physical, genetic, congenital, developmental, behavioral, or mental conditions, injuries, or disabilities.

(c) UPDATES TO DEFINITION.—The Secretary of Health and Human Services, in consultation with experts in the field of pediatric care and key stakeholders, including patient and family groups, shall review and update this definition on a biennial basis, consistent with up-to-date standards of pediatric healthcare practice that are based on—

(1) the views of pediatric healthcare providers and experts practicing in relevant clinical areas;

(2) recommendations of medical-specialty societies, other pediatric healthcare provider organizations, and family and patient groups, and

(3) credible scientific evidence published in peer-reviewed literature that is generally recognized by the relevant health care provider community.

SEC. 133. SAFE STAFFING REQUIREMENTS.

(a) MINIMUM DIRECT CARE REGISTERED NURSE STAFFING REQUIREMENTS.—The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following new title:

"TITLE XXXIV—MINIMUM DIRECT CARE REGISTERED NURSE STAFFING REQUIREMENT

"SEC. 3401. MINIMUM NURSE STAFFING REQUIREMENT.

''(a) STAFFING PLAN.—

''(1) IN GENERAL.—A hospital shall implement a staffing plan that—

''(A) provides adequate, appropriate, and quality delivery of health care services and protects patient safety; and

"(B) is consistent with the requirements of this title.

"(2) EFFECTIVE DATES.—

"(A) IMPLEMENTATION OF STAFFING PLAN.—Subject to subparagraph (B), the requirements under paragraph (1) shall take effect on a date to be determined by the Secretary, but not later than 1 year after the date of the enactment of this title.

"(B) APPLICATION OF MINIMUM DIRECT CARE REGISTERED NURSE-TO-PATIENT RATIOS.—The requirements under subsection (b) shall take effect as soon as practicable, as determined by the Secretary, but not later than—

"(i) 2023; and

"(ii) in the case of a hospital in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act), 2025.

"(b) MINIMUM DIRECT CARE REGISTERED NURSE-TO-PATIENT RATIOS.—

"(1) IN GENERAL.—Except as provided in paragraph (4) and other provisions of this section, a hospital's staffing plan shall provide that, at all times during each shift within a unit of the hospital, and

with a full complement of ancillary and support staff, a direct care registered nurse may be assigned to not more than the following number of patients in that unit:

"(A) One patient in trauma emergency units.

"(B) One patient in operating room units, provided that a minimum of 1 additional person serves as a scrub assistant in such unit.

"(C) Two patients in critical care units, including neonatal intensive care units, emergency critical care and intensive care units, labor and delivery units, coronary care units, acute respiratory care units, postanesthesia units, and burn units.

"(D) Three patients in emergency room units, pediatrics units, stepdown units, telemetry units, antepartum units, and combined labor, deliver, and postpartum units.

"(E) Four patients in medical-surgical units, intermediate care nursery units, acute care psychiatric units, and other specialty care units.

"(F) Five patients in rehabilitation units and skilled nursing units.

''(G) Six patients in postpartum (3 couplets) units and well-baby nursery units.

''(2) SIMILAR UNITS WITH DIFFERENT NAMES.—The Secretary may apply minimum direct care registered nurse-to-patient ratios established in paragraph (1) for a hospital unit referred to in such paragraph to a type of hospital unit not referred to in such paragraph if such type of hospital unit provides a level of care to patients whose needs are similar to the needs of patients cared for in the hospital unit referred to in such paragraph.

''(3) APPLICATION OF RATIOS TO HOSPITAL NURSING PRACTICE STANDARDS.—

''(A) IN GENERAL.—A patient assignment may be included in the calculation of the direct care registered nurse-to-patient ratios required in this subsection only if care is provided by a direct care registered nurse and the provision of care to the particular patient is within that direct care registered nurse's competence.

''(B) DEMONSTRATION OF UNIT-SPECIFIC COMPETENCE.—A hospital shall not assign a direct care registered nurse to a hospital unit unless that hospital determines that the direct care registered nurse has demonstrated current

competence in providing care in that unit, and has also received orientation to that hospital's unit sufficient to provide competent care to patients in that unit.

"(C) DUTIES OF THE ASSIGNED DIRECT CARE REGISTERED NURSE.—Each patient shall be assigned to a direct care registered nurse who shall directly provide the assessment, planning, supervision, implementation, and evaluation of the nursing care provided to the patient at least every shift and has the responsibility for the provision of care to a particular patient within his or her scope of practice.

"(D) NURSE ADMINISTRATORS AND SUPERVISORS.—A registered nurse who is a nurse administrator, nurse supervisor, nurse manager, charge nurse, case manager, or any other hospital administrator or supervisor, shall not be included in the calculation of the direct care registered nurse-to-patient ratio unless that nurse has a current and active direct patient care assignment and provides direct patient care in compliance with the requirements of this section, including competency requirements. The exemption in this subsection shall apply

only during the hours in which the individual registered nurse has the principal responsibility of providing direct patient care and has no additional job duties as would a direct care registered nurse.

''(E) OTHER PERSONNEL.—Other personnel may perform patient care tasks based on their training and demonstrated skill but may not perform or assist in direct care registered nurse functions unless authorized to do in accordance with State scope of practice laws and regulations.

''(F) TEMPORARY NURSING PERSONNEL.—A hospital shall not assign any nursing personnel from temporary nursing agencies patient care to any hospital unit without such personnel having demonstrated competence on the assigned unit and received orientation to that hospital's unit sufficient to provide competent care to patients in that unit.

''(G) ANCILLARY AND ADDITIONAL STAFFING.—The need for additional staffing of direct care registered nurses, licensed vocational or practical nurses, licensed psychiatric technicians, certified nursing or patient care assist-

ants, or other licensed or unlicensed ancillary staff above the minimum registered nurse-to-patient ratios shall be based on the assessment of the individual patient's nursing care requirement, the individual patient's nursing care plan, and acuity level.

''(4) RESTRICTIONS.—

''(A) PROHIBITION AGAINST AVERAGING.—A hospital shall not average the number of patients and the total number of direct care registered nurses assigned to patients in a hospital unit during any 1 shift or over any period of time for purposes of meeting the requirements under this subsection.

''(B) PROHIBITION AGAINST IMPOSITION OF MANDATORY OVERTIME REQUIREMENTS.—A hospital shall not impose mandatory overtime requirements to meet the hospital unit direct care registered nurse-to-patient ratios required under this subsection.

''(C) RELIEF DURING ROUTINE ABSENCES.—A hospital shall ensure that only a direct care registered nurse who has demonstrated current competence to the hospital in providing care on a particular unit and has also

received orientation to that hospital's unit sufficient to provide competent care to patients in that unit may relieve another direct care registered nurse during breaks, meals, and other routine, expected absences from a hospital unit.

"(D) APPLICATION OF DIRECT CARE REGISTERED NURSE-TO-PATIENT RATIOS IN PATIENT-ACUITY ADJUSTABLE UNITS.—Patients shall be cared for only on units or patient care areas where the direct care registered nurse-to-patient ratios meet the level of intensity, type of care, and the individual requirements and needs of each patient. Notwithstanding paragraph (2), hospitals that provide patient care in units or patient care areas that are acuity adaptable or acuity adjustable shall apply the direct care registered nurse-to-patient ratio required in this section for the highest patient acuity level or level of care in that unit or patient care area, and shall comply with all other requirements of this section.

"(E) USE OF VIDEO MONITORS.—A hospital shall not employ video monitors or any form of electronic visualization of a patient as a substitute for the direct observation required

for patient assessment by the direct care registered nurse or required for patient protection. Video monitors or any form of electronic visualization of a patient shall not be included in the calculation of the direct care registered nurse-to-patient ratio required in this subsection and shall not replace the requirement of paragraph (3)(D) that each patient shall be assigned to a direct care registered nurse who shall directly provide the assessment, planning, supervision, implementation, and evaluation of the nursing care provided to the patient at least every shift and have the responsibility for the provision of care to a particular patient within his or her scope of practice.

''(F) USE OF OTHER TECHNOLOGY.—A hospital shall not employ technology that substitutes for the assigned registered nurse's professional judgment in assessment, planning, implementation, and evaluation of care.

''(5) ADJUSTMENT OF RATIOS.—

''(A) IN GENERAL.—If necessary to protect patient safety, the Secretary may prescribe regulations that—

"(i) increase minimum direct care registered nurse-to-patient ratios under this subsection to reduce the number of patients that may be assigned to each direct care nurse; or

"(ii) add minimum direct care registered nurse-to-patient ratios for units not referred to in paragraphs (1) and (2).

"(B) CONSULTATION.—Such regulations shall be prescribed after consultation with affected hospitals and registered nurses.

"(6) ANCILLARY AND ADDITIONAL STAFFING.—

"(A) IN GENERAL.—The Secretary may prescribe regulations requiring additional staffing of direct care registered nurses, licensed vocational or practice nurses, licensed psychiatric technicians, certified nursing or patient care assistants, or other licensed or unlicensed ancillary staff above the minimum registered nurse-to-patient ratios that is based on the assessment of the individual patient's nursing care needs, the individual patient's nursing care plan, and acuity level.

"(B) CONSULTATION.—Such regulations shall be prescribed after consultation with af-

fected hospitals, registered nurses, and ancillary staff.

''(7) RELATIONSHIP TO STATE-IMPOSED RATIOS.—Nothing in this title shall preempt State standards that the Secretary determines to be as stringent as Federal requirements for a staffing plan established under this title. Minimum direct care registered nurse-to-patient ratios established under this subsection shall not preempt State requirements that the Secretary determines are as stringent as to Federal requirements for direct care registered nurse-to-patient ratios established under this title.

''(8) EXEMPTION IN EMERGENCIES.—The requirements established under this subsection shall not apply during a state of emergency if a hospital is requested or expected to provide an exceptional level of emergency or other medical services. If a hospital seeks to apply the exemption under this paragraph in response to a complaint filed against the hospital for a violation of the provisions of this title, the hospital must demonstrate that prompt and diligent efforts were made to maintain required staffing levels. The Secretary shall issue guidance to hospitals that describes situations that constitute a state of emergency for purposes of the exemption

under this paragraph and shall establish necessary penalties for violations of this paragraph consistent with section 3406.

''(c) DEVELOPMENT AND REEVALUATION OF STAFFING PLAN.—

''(1) CONSIDERATIONS IN DEVELOPMENT OF PLAN.—In developing the staffing plan, a hospital shall provide for direct care registered nurse-to-patient ratios above the minimum direct care registered nurse-to-patient ratios required under subsection (b) if appropriate based upon consideration of, at a minimum, the following factors:

''(A) The number of patients on a particular unit on a shift-by-shift basis.

''(B) The acuity level and nursing care plan of patients on a particular unit on a shift-by-shift basis.

''(C) The anticipated admissions, discharges, and transfers of patients during each shift that impacts direct patient care.

''(D) Specialized experience required of direct care registered nurses on a particular unit.

''(E) Staffing levels and services provided by licensed vocational or practical nurses, licensed psychiatric technicians, certified nurse

assistants, or other ancillary staff in meeting direct patient care needs not required by a direct care registered nurse.

''(F) The level of familiarity with hospital practices, policies, and procedures by temporary agency direct care registered nurses used during a shift.

''(G) Obstacles to efficiency in the delivery of patient care presented by physical layout.

''(2) DOCUMENTATION OF STAFFING.—A hospital shall specify the system used to document actual staffing in each unit for each shift.

''(3) ANNUAL REEVALUATION OF PLAN.—

''(A) IN GENERAL.—A hospital shall annually evaluate its staffing plan in each unit in relation to actual patient care requirements.

''(B) UPDATE.—A hospital shall update its staffing plan to the extent appropriate based on such evaluation.

''(4) TRANSPARENCY.—

''(A) IN GENERAL.—Any staffing plan or method used to create and evaluate acuity-level and adopted by a hospital under this section shall be transparent in all respects, including disclosure of detailed documentation of the

methodology used to determine nursing staffing, identifying each factor, assumption, and value used in applying such methodology.

''(B) PUBLIC AVAILABILITY.—The Secretary shall establish procedures to provide that the documentation submitted under subsection (d) is available for public inspection in its entirety.

''(5) REGISTERED NURSE PARTICIPATION.—A staffing plan of a hospital—

''(A) shall be developed and subsequent reevaluations shall be conducted under this subsection on the basis of input from direct care registered nurses at the hospital from each unit or patient care area; and

''(B) where such nurses are represented through collective bargaining, shall require bargaining with the applicable recognized or certified collective bargaining representative of such nurses.

Nothing in this title shall be construed to permit conduct prohibited under the National Labor Relations Act or chapter 71 of title 5, United States Code.

''(6) STAFFING COMMITTEES.—If a hospital maintains a staffing committee, then the committee shall include at least one registered nurse from each hospital unit and shall be composed of at least 50 percent direct care registered nurses. The staffing committee shall include meaningful representation of other direct care nonmanagement staff. Direct care registered nurses who serve on the committee shall be selected by other direct care registered nurses from their unit. Other direct care nonmanagement staff shall be selected by other direct care nonmanagement staff. Participation on staffing committees shall be considered a part of the employee's regularly scheduled workweek.

''(d) SUBMISSION OF PLAN TO SECRETARY.—A hospital shall submit to the Secretary its staffing plan and any annual updates under subsection (c)(3)(B). A federally operated hospital may submit its staffing plan through the department or agency operating the hospital.

''SEC. 3402. POSTING, RECORDS, AND AUDITS.

''(a) POSTING REQUIREMENTS.—In each unit, a hospital shall post a uniform notice in a form specified by the Secretary in regulation that—

''(1) explains requirements imposed under section 3401;

''(2) includes actual direct care registered nurse-to-patient ratios during each shift;

''(3) includes the actual number and titles of direct care registered nurses assigned during each shift; and

''(4) is visible, conspicuous, and accessible to staff, patients, and the public.

''(b) RECORDS.—

''(1) MAINTENANCE OF RECORDS.—Each hospital shall maintain accurate records of actual direct care registered nurse-to-patient ratios in each unit for each shift for no less than 3 years. Such records shall include—

''(A) the number of patients in each unit;

''(B) the identity and duty hours of—

''(i) each direct care registered nurse assigned to each patient in each unit in each shift; and

''(ii) ancillary staff who are under the coordination of the direct care registered nurse;

''(C) certification that each nurse received rest and meal breaks and the identity and duty hours of each direct care registered nurse who provided such relief; and

''(D) a copy of each notice posted under subsection (a).

''(2) AVAILABILITY OF RECORDS.—Each hospital shall make its records maintained under paragraph (1) available to—

''(A) the Secretary;

''(B) registered nurses and their collective bargaining representatives (if any); and

''(C) the public under regulations established by the Secretary, or in the case of a federally operated hospital, under section 552 of title 5, United States Code (commonly known as the Freedom of Information Act).

''(c) AUDITS.—The Secretary shall conduct periodic audits to ensure—

''(1) implementation of the staffing plan in accordance with this title; and

''(2) accuracy in records maintained under this section.

''SEC. 3403. MINIMUM DIRECT CARE LICENSED PRACTICAL NURSE STAFFING REQUIREMENTS.

''(a) ESTABLISHMENT.—A hospital's staffing plan shall comply with minimum direct care licensed practical nurse staffing requirements that the Secretary establishes for units in hospitals. Such staffing requirements shall be

established not later than 18 months after the date of the enactment of this title, and shall be based on the study conducted under subsection (b).

''(b) STUDY.—Not later than 1 year after the date of the enactment of this title, the Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall complete a study of licensed practical nurse staffing and its effects on patient care in hospitals. The Director may contract with a qualified entity or organization to carry out such study under this paragraph. The Director shall consult with licensed practical nurses and organizations representing licensed practical nurses regarding the design and conduct of the study.

''(c) APPLICATION OF REGISTERED NURSE PROVISIONS TO LICENSED PRACTICAL NURSE STAFFING REQUIREMENTS.—Paragraphs (2), (4)(A), (4)(B), (4)(C), and (6) of section 3401(b), paragraphs (1), (2), (3), and (4) of section 3401(c), and section 3402 shall apply to the establishment and application of direct care licensed practical nurse staffing requirements under this section pursuant to the additional staffing requirements under subsection (b)(3)(G) of section 3401 and in the same manner that they apply to the establishment and application of direct care registered nurse-to-patient ratios under sections 3401 and 3402.

''(d) EFFECTIVE DATE.—The requirements of this section shall take effect as soon as practicable, as determined by the Secretary, but not later than—

''(1) 2 years after the date of the enactment of this title; and

''(2) in the case of a hospital in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act), 4 years after the date of the enactment of this title.

''(e) STUDY.—Not later than 1 year after the date of the enactment of this title, the Secretary, acting through the Director of the Agency for Healthcare Research and Quality shall complete a study of registered and practical nurse staffing requirements in clinics and other outpatient settings, and its effects on patient care in outpatient settings. The Director may contract with a qualified entity or organization to carry out such study under this subsection. The Director shall consult with registered nurses and licensed practice nurses working in outpatient settings, including professional nursing associations and labor organizations representing both registered and practice nurses working in outpatient settings regarding the design and conduct of the study.

"SEC. 3404. WHISTLEBLOWER AND PATIENT PROTECTIONS.

''(a) PROFESSIONAL OBLIGATION AND RIGHTS.—All nurses have a duty and right to act based on their professional judgment in accordance with State nursing laws and regulations of the State in which the direct nursing care is being performed and to provide care in the exclusive interests of the patients and to act as the patient's advocate.

''(b) ACCEPTANCE OF PATIENT CARE ASSIGNMENTS.—The nurse is responsible for providing competent, safe, therapeutic, and effective nursing care to assigned patients. Before accepting a patient assignment, a nurse shall—

''(1) have the necessary professional knowledge, judgment, skills, and ability to provide the required care;

''(2) determine using professional judgment in accordance with State nursing laws and regulations of the State in which the direct nursing care is being performed whether the nurse is competent to perform the nursing care required; and

''(3) determine whether acceptance of a patient assignment would expose the patient or nurse to risk of harm.

''(c) OBJECTION TO OR REFUSAL OF ASSIGNMENT.—A nurse may object to, or refuse to participate in, any

activity, policy, practice, assignment, or task if in good faith—

''(1) the nurse reasonably believes it to be in violation of section 3401 or 3403; or

''(2) the nurse is not prepared by education, training, or experience to fulfill the assignment without compromising the safety of any patient or jeopardizing the license of the nurse.

''(d) RETALIATION FOR OBJECTION TO OR REFUSAL OF ASSIGNMENT BARRED.—

''(1) NO DISCHARGE, DISCRIMINATION, OR RETALIATION.—No hospital shall discharge, retaliate, discriminate, or otherwise take adverse action in any manner with respect to any aspect of a nurse's employment (as defined in section 3407), including discharge, promotion, compensation, or terms, conditions, or privileges of employment, based on the nurse's refusal of a work assignment under subsection (c).

''(2) NO FILING OF COMPLAINT.—No hospital shall file a complaint or a report against a nurse with a State professional disciplinary agency because of the nurse's refusal of a work assignment under subsection (c).

''(e) CAUSE OF ACTION.—Any nurse, collective bargaining representative, or legal representative of any nurse who has been discharged, discriminated against, or retaliated against in violation of subsection (d)(1) or against whom a complaint or report has been filed in violation of subsection (d)(2) may (without regard to whether a complaint has been filed under subsection (f) of this section or subsection (b) of section 3406) bring a cause of action in a United States district court. A nurse who prevails on the cause of action shall be entitled to one or more of the following:

''(1) Reinstatement.

''(2) Reimbursement of lost wages, compensation, and benefits.

''(3) Attorneys' fees.

''(4) Court costs.

''(5) Other damages.

''(f) COMPLAINT TO SECRETARY.—A nurse, patient, collective bargaining representative, or other individual may file a complaint with the Secretary against a hospital that violates the provisions of this title. For any complaint filed, the Secretary shall—

''(1) receive and investigate the complaint;

''(2) determine whether a violation of this title as alleged in the complaint has occurred; and

''(3) if such a violation has occurred, issue an order that the complaining nurse or individual shall not suffer any discharge, retaliation, discrimination, or other adverse action prohibited by subsection (d) or subsection (h).

''(g) TOLL-FREE TELEPHONE NUMBER.—

''(1) IN GENERAL.—The Secretary shall provide for the establishment of a toll-free telephone hotline to provide information regarding the requirements under sections 3401 through 3403 and to receive reports of violations of such section.

''(2) NOTICE TO PATIENTS.—A hospital shall provide each patient admitted to the hospital for inpatient care with the hotline described in paragraph (1), and shall give notice to each patient that such hotline may be used to report inadequate staffing or care.

''(h) PROTECTION FOR REPORTING.—

''(1) PROHIBITION ON RETALIATION OR DISCRIMINATION.—A hospital shall not discriminate or retaliate in any manner against any patient, employee, or contract employee of the hospital, or any other individual, on the basis that such individual, in good faith, individually or in conjunction with another person or persons, has presented a grievance

or complaint, or has initiated or cooperated in any investigation or proceeding of any governmental entity, regulatory agency, or private accreditation body, made a civil claim or demand, or filed an action relating to the care, services, or conditions of the hospital or of any affiliated or related facilities.

''(2) GOOD FAITH DEFINED.—For purposes of this subsection, an individual shall be deemed to be acting in good faith if the individual reasonably believes—

''(A) the information reported or disclosed is true; and

''(B) a violation of this title has occurred or may occur.

''(i) PROHIBITION ON INTERFERENCE WITH RIGHTS.—

''(1) EXERCISE OF RIGHTS.—It shall be unlawful for any hospital to—

''(A) interfere with, restrain, or deny the exercise, or attempt to exercise, by any person of any right provided or protected under this title; or

''(B) coerce or intimidate any person regarding the exercise or attempt to exercise such right.

''(2) OPPOSITION TO UNLAWFUL POLICIES OR PRACTICES.—It shall be unlawful for any hospital to discriminate or retaliate against any person for opposing any hospital policy, practice, or actions which are alleged to violate, breach, or fail to comply with any provision of this title.

''(3) PROHIBITION ON INTERFERENCE WITH PROTECTED COMMUNICATIONS.—A hospital (or an individual representing a hospital) shall not make, adopt, or enforce any rule, regulation, policy, or practice which in any manner directly or indirectly prohibits, impedes, or discourages a direct care nurse from, or intimidates, coerces, or induces a direct care nurse regarding, engaging in free speech activities or disclosing information as provided under this title.

''(4) PROHIBITION ON INTERFERENCE WITH COLLECTIVE ACTION.—A hospital (or an individual representing a hospital) shall not in any way interfere with the rights of nurses to organize, bargain collectively, and engage in concerted activity under section 7 of the National Labor Relations Act (29 U.S.C. 157).

''(j) NOTICE.—A hospital shall post in an appropriate location in each unit a conspicuous notice in a form specified by the Secretary that—

''(1) explains the rights of nurses, patients, and other individuals under this section;

''(2) includes a statement that a nurse, patient, or other individual may file a complaint with the Secretary against a hospital that violates the provisions of this title; and

''(3) provides instructions on how to file such a complaint.

''(k) EFFECTIVE DATE.—

''(1) REFUSAL; RETALIATION; CAUSE OF ACTION.—

''(A) IN GENERAL.—Subsections (c) through (e) shall apply to objections and refusals occurring on or after the effective date of the provision of this title to which the objection or refusal relates.

''(B) EXCEPTION.—Subsection (c)(2) shall not apply to objections or refusals in any hospital before the requirements of section 3401(a) or 3403(a), as applicable, apply to that hospital.

''(2) PROTECTIONS FOR REPORTING.—Subsection (h)(1) shall apply to actions occurring on or after the effective date of the provision to which the violation relates, except that such subsection shall apply to initiation, cooperation, or participation in an investigation or proceeding on or after the date of enactment of this title.

''(3) NOTICE.—Subsection (j) shall take effect 18 months after the date of enactment of this title.

''SEC. 3405. ENFORCEMENT.

''(a) IN GENERAL.—The Secretary shall enforce the requirements and prohibitions of this title in accordance with this section.

''(b) PROCEDURES FOR RECEIVING AND INVESTIGATING COMPLAINTS.—The Secretary shall establish procedures under which—

''(1) any person may file a complaint alleging that a hospital has violated a requirement or a prohibition of this title; and

''(2) such complaints shall be investigated by the Secretary.

''(c) REMEDIES.—If the Secretary determines that a hospital has violated a requirement of this title, the Secretary—

''(1) shall require the facility to establish a corrective action plan to prevent the recurrence of such violation; and

''(2) may impose civil money penalties, as described in subsection (d).

''(d) CIVIL PENALTIES.—

''(1) IN GENERAL.—In addition to any other penalties prescribed by law, the Secretary may impose civil penalties as follows:

''(A) HOSPITAL LIABILITY.—The Secretary may impose on a hospital found to be in violation of this title a civil money penalty of—

''(i) not more than $25,000 for the first knowing violation of this title by such hospital; and

''(ii) not more than $50,000 for any subsequent knowing violation of this title by such hospital.

''(B) INDIVIDUAL LIABILITY.—The Secretary may impose on an individual who—

''(i) is employed by a hospital found by the Secretary to have violated this title; and

''(ii) knowingly violates this title,

a civil money penalty of not more than $20,000 for each such violation by the individual.

''(2) PROCEDURES.—The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply with respect to a civil money penalty or proceeding under this subsection in the same manner as such provisions apply with respect to a civil money penalty or proceeding under such section 1128A.

''(e) PUBLIC NOTICE OF VIOLATIONS.—

''(1) INTERNET WEBSITE.—The Secretary shall publish on the internet website of the Department of Health and Human Services the names of hospitals on which a civil money penalty has been imposed under this section, the violation for which such penalty was imposed, and such additional information as the Secretary determines appropriate.

''(2) CHANGE OF OWNERSHIP.—With respect to a hospital that had a change of ownership, as determined by the Secretary, penalties imposed on the hospital while under previous ownership shall no longer be published by the Secretary pursuant to paragraph (1) after the 1-year period beginning on the date of change of ownership.

''(f) USE OF FUNDS.—Funds collected by the Secretary pursuant to this section are authorized to be appropriated to carry out this title.

"SEC. 3406. DEFINITIONS.

''For purposes of this title:

''(1) ACUITY LEVEL.—The term 'acuity level' means the determination, using a hospital acuity measurement tool that has been developed and established in coordination with direct care registered nurses and made transparent pursuant to section 3401(c)(4), of nursing care requirements, based on the assigned direct care registered nurse's professional judgment of—

''(A) the severity and complexity of an individual patient's illness or injury;

''(B) the need for specialized equipment; and

''(C) the intensity of nursing interventions required.

''(2) COMPETENCE.—The term 'competence' or 'competent' means the satisfactory application of the duties and responsibilities of a registered nurse in providing nursing care to specific patient populations and for acuity levels for each patient care unit or area pursuant to the State nursing laws and

regulations of the State in which the direct nursing care is being performed.

''(3) DIRECT CARE LICENSED PRACTICAL NURSE.—The term 'direct care licensed practical nurse' means an individual who has been granted a license by at least one State to practice as a licensed practical nurse or a licensed vocational nurse and who provides bedside care for one or more patients.

''(4) DIRECT CARE REGISTERED NURSE.—The term 'direct care registered nurse' means an individual who has been granted a license by at least one State to practice as a registered nurse and who provides bedside care for one or more patients.

''(5) EMPLOYMENT.—The term 'employment' includes the provision of services under a contract or other arrangement.

''(6) HOSPITAL.—The term 'hospital' has the meaning given that term in section 1861(e) of the Social Security Act.

''(7) NURSE.—The term 'nurse' means any direct care registered nurse or direct care licensed practice nurse (as the case may be), regardless of whether or not the nurse is an employee.

''(8) NURSING CARE PLAN.—The term 'nursing care plan' means a plan developed by the assigned

direct care registered nurse (in accordance with nursing law in the State in which the nursing care is performed) that indicates the nursing care to be given to individual patients that—

''(A) considers the acuity level of the patient;

''(B) is developed in coordination with the patient, the patient's family, or other representatives when appropriate, and staff of other disciplines involved in the care of the patient;

''(C) reflects all elements of the nursing process; and

''(D) recommends the number and skill mix of additional licensed and unlicensed direct care staff needed to fully implement the nursing care plan.

''(9) PROFESSIONAL JUDGMENT.—The term 'professional judgment' means, in accordance with State nursing laws and regulations of the State in which the direct nursing care is being performed, the direct care registered nurse's application of knowledge, expertise, and experience in conducting a comprehensive nursing assessment of each patient and in making independent decisions about patient care including the need for additional staff.

''(10) STAFFING PLAN.—The term 'staffing plan' means a staffing plan required under section 3401.

''(11) STATE OF EMERGENCY.—The term 'state of emergency'—

''(A) means a state of emergency that is an unpredictable or unavoidable occurrence at an unscheduled or unpredictable interval, relating to health care delivery and requiring immediate medical interventions and care; and

''(B) does not include a state of emergency that results from a labor dispute in the health care industry or consistent understaffing.

''SEC. 3407. RULE OF CONSTRUCTION.

''Nothing in this title shall be construed to authorize disclosure of private and confidential patient information, if such disclosure is not authorized or required by other applicable law.''.

(b) RECOMMENDATIONS TO CONGRESS.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report containing recommendations for ensuring that sufficient numbers of nurses are available to meet the requirements imposed by title XXXIV of the Public Health Service Act, as added by subsection (a).

(c) REPORT BY HRSA.—

(1) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Administrator of the Health Resources and Services Administration, in consultation with the National Health Care Workforce Commission, shall submit to Congress a report regarding the relationship between nurse staffing levels and nurse retention in hospitals.

(2) UPDATED REPORT.—Not later than 5 years after the date of enactment of this Act, the Administrator of the Health Resources and Services Administration, in consultation with the National Health Care Workforce Commission, shall submit to Congress an update of the report submitted under paragraph (1).

(d) ENFORCEMENT OF REQUIREMENTS THROUGH FEDERAL PROGRAMS.—

(1) MEDICARE PROGRAM.—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

(A) in subparagraph (X), by striking ", and" and inserting a comma;

(B) in subparagraph (Y), by striking the period at the end and inserting ", and"; and

(C) by inserting after subparagraph (Y) the following new subparagraph:

''(Z) in the case of a hospital, to comply with the provisions of title XXXIV of the Public Health Service Act.''.

(2) MEDICAID PROGRAM.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(A) by striking ''and'' at the end of paragraph (82);

(B) by striking the period at the end of paragraph (83) and inserting ''; and''; and

(C) by inserting after paragraph (83) the following new paragraph:

''(84) provide that any hospital that receives a payment under such plan comply with the provisions of title XXXIV of the Public Health Service Act (relating to minimum direct care registered nurse staffing requirements).''.

(e) NURSING HOMES.—No later than one year after enactment of this Act, the Secretary of Health and Human Services shall promulgate a rule for minimum staffing standards for skilled nursing facilities under the Medicare program and for nursing facilities under the

Medicaid program that align with the standards set in this section.

SEC. 134. ENHANCEMENTS FOR REDUCED COST-SHARING.

(a) IN GENERAL.—Section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071) is amended—

(1) in subsection (b)(1), by striking ''silver'' and inserting ''gold'';

(2) by amending subsection (c)(1)(B) to read as follows:

''(B) COORDINATION WITH ACTUARIAL LIMITS.—The Secretary shall ensure the reduction under this paragraph shall not result in the plan's share of the total allowed costs of benefits provided under the plan becoming less than—

''(i) 95 percent in the case of an eligible insured described in paragraph (2)(A);

''(ii) 90 percent in the case of an eligible insured described in paragraph (2)(B); and

''(iii) 85 percent in the case of an eligible insured described in paragraph (2)(C).''; and

(3) by amending subsection (c)(2) to read as follows:

''(2) ADDITIONAL REDUCTION.—The Secretary shall establish procedures under which the issuer of a qualified health plan to which this section applies shall further reduce cost-sharing under the plan in a manner sufficient to—

''(A) in the case of an eligible insured whose household income is not less than 100 percent but not more than 200 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 95 percent of such costs;

''(B) in the case of an eligible insured whose household income is more than 200 percent but not more than 300 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 90 percent of such costs; and

''(C) in the case of an eligible insured whose household income is more than 300 percent but not more than 400 percent of the poverty line for a family of the size involved, in-

crease the plan's share of the total allowed costs of benefits provided under the plan to 85 percent of such costs.''.

(b) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan years beginning after December 31, 2019.

(c) FUNDING.—Section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071) is amended by adding at the end the following new subsection:

''(g) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary such sums as may be necessary for payments under this section.''.

SEC. 135. REPEAL OF BONUS PAYMENTS FOR MEDICARE ADVANTAGE PLANS.

Section 1853(o) of the Social Security Act (42 U.S.C. 1395w–23(o)) is repealed.

TITLE II—TAX PROVISIONS

SEC. 201. SUNSET OF PUBLIC LAW 115–97.

(a) IN GENERAL.—All provisions of, and amendments made by, Public Law 115–97 shall not apply to calendar, taxable, plan, or limitation years beginning after December 31, 2019.

(b) APPLICATION OF CERTAIN LAWS.—The Internal Revenue Code of 1986 shall be applied and administered

to years described in subsection (a) as if the provisions and amendments described in subsection (a) had never been enacted.

SEC. 202. SURTAX.

There is hereby imposed a tax of 5 percent on the adjusted gross income of each taxpayer to the extent such income exceeds $500,000.

SEC. 203. BASIS OF PROPERTY ACQUIRED FROM A DECEDENT.

(a) IN GENERAL.—Section 1014 of the Internal Revenue Code of 1986 is amended by striking ''person, be'' and all that follows through the period at the end and inserting the following: ''person, be the basis in the hands of the decedent.''.

(b) EFFECTIVE DATE.—The amendments made by this section to property acquired or passed after the date of enactment of this Act.

SEC. 204. MEDICARE PAYROLL TAX.

(a) IN GENERAL.—Section 3101(b)(2) of the Internal Revenue Code of 1986 is amended by striking ''0.9 percent'' and inserting ''4 percent''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to taxable years beginning after the date of the enactment of this Act.

SEC. 205. NET INVESTMENT INCOME TAX.

(a) IN GENERAL.—Section 1411(a) of the Internal Revenue Code of 1986 is amended by striking ''3.8 percent'' each place such term appears and inserting ''6.9 percent''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to taxable years beginning after the date of the enactment of this Act.

SEC. 206. TERMINATION OF DEDUCTION FOR CONTRIBUTIONS TO HEALTH SAVINGS ACCOUNTS.

Section 223(b) of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

''(9) TERMINATION OF DEDUCTION.—Notwithstanding any other provision of this subsection, the monthly limitation for any month beginning after December 31, 2023, is zero.''.

SEC. 207. INCREASE IN EXCISE TAX ON SMALL CIGARS AND CIGARETTES AND OTHER TOBACCO PRODUCTS.

(a) SMALL CIGARS.—Section 5701(a)(1) of the Internal Revenue Code of 1986 is amended by striking ''$50.33'' and inserting ''$100.66''.

(b) CIGARETTES.—Section 5701(b) of such Code is amended—

(1) by striking ''$50.33'' in paragraph (1) and inserting ''$100.66''; and

(2) by striking ''$105.69'' in paragraph (2) and inserting ''$211.38''.

(c) PIPE TOBACCO.—Section 5701(f) of the Internal Revenue Code of 1986 is amended by striking ''$2.8311 cents'' and inserting ''$50.00''.

(d) ROLL-YOUR-OWN TOBACCO.—Section 5701(g) of such Code is amended by striking ''$24.78'' and inserting ''$49.56''.

(e) LARGE CIGARS.—Paragraph (2) of section 5701(a) of the Internal Revenue Code of 1986 is amended by striking ''52.75 percent'' and all that follows through the period and inserting ''$24.78 per pound (and a proportionate tax at the like rate on all fractional parts of a pound) but not less than 5.033 cents per cigar.''.

(f) SMOKELESS TOBACCO.—

(1) IN GENERAL.—Section 5701(e) of the Internal Revenue Code of 1986 is amended—

(A) in paragraph (1), by striking ''$1.51'' and inserting ''$28.04'';

(B) in paragraph (2), by striking ''50.33 cents'' and inserting ''$12.42''; and

(C) by adding at the end the following:

''(3) SMOKELESS TOBACCO SOLD IN DISCRETE SINGLE-USE UNITS.—On discrete single-use units, $107.65 per each 1,000 single-use units.''.

(2) DISCRETE SINGLE-USE UNIT.—Section 5702(m) of such Code is amended—

(A) in paragraph (1), by striking ''or chewing tobacco'' and inserting ''chewing tobacco, discrete single-use unit'';

(B) in paragraphs (2) and (3), by inserting ''that is not a discrete single-use unit'' before the period in each such paragraph; and

(C) by adding at the end the following:

''(4) DISCRETE SINGLE-USE UNIT.—The term 'discrete single-use unit' means any product containing tobacco that—

''(A) is not intended to be smoked; and

''(B) is in the form of a lozenge, tablet, pill, pouch, dissolvable strip, or other discrete single-use or single-dose unit''.

SEC. 208. EXCISE TAX ON ALCOHOL.

(a) DISTILLED SPIRITS.—Section 5001(a)(1) of the Internal Revenue Code of 1986 is amended by striking ''$13.50'' and inserting ''$16.00''.

(b) WINE.—(1) Section 5041(b)(1) of the Internal Revenue Code of 1986 is amended by striking ''$1.07 per wine gallon'' and inserting ''$16.00 per proof gallon''.

(2) Section 5041(b)(2) of the Internal Revenue Code of 1986 is amended by striking ''$1.57 per wine gallon'' and inserting ''$16.00 per proof gallon''.

(3) Section 5041(b)(3) of the Internal Revenue Code of 1986 is amended by striking ''$3.15 per wine gallon'' and inserting ''$16.00 per proof gallon''.

(4) Section 5041(b)(4) of the Internal Revenue Code of 1986 is amended by striking ''$3.40 per wine gallon'' and inserting ''$16.00 per proof gallon''.

(5) Section 5041(b)(5) of the Internal Revenue Code of 1986 is amended by striking ''$3.30 per wine gallon'' and inserting ''$16.00 per proof gallon''.

(6) Section 5041(b)(3) of the Internal Revenue Code of 1986 is amended by striking ''$22.6 cents per wine gallon'' and inserting ''$16.00 per proof gallon''.

(c) BEER.—Section 5051(B) of the Internal Revenue Code of 1986 is amended by striking ''$18 for per barrel'' and inserting ''$16 per proof gallon''.

SEC. 209. TAX ON SUGARED DRINKS.

(a) IN GENERAL.—Subchapter D of chapter 32 of the Internal Revenue Code of 1986 is amended by inserting after part I the following new part:

"PART II—SUGAR-SWEETENED BEVERAGES

"SEC. 4171. IMPOSITION OF TAX.

"(a) IN GENERAL.—There is hereby imposed a tax on the sale or transfer of any specified sugar-sweetened beverage product by the manufacturer, producer, or importer thereof.

"(b) RATE OF TAX.—The rate of tax imposed under subsection (a) shall be equal to one cent per 4.2 grams of caloric sweetener contained in such specified sugar-sweetened beverage product.

"(c) PERSONS LIABLE FOR TAX.—The manufacturer, producer, or importer referred to in subsection (a) shall be liable for the tax imposed by such subsection.

"SEC. 4172. DEFINITIONS.

"(a) SPECIFIED SUGAR-SWEETENED BEVERAGE PRODUCT.—For purposes of this part—

"(1) IN GENERAL.—For purposes of this part, the term 'specified sugar-sweetened beverage product' means—

"(A) any liquid intended for human consumption which contains a caloric sweetener, and

"(B) any liquid, or solid mixture of ingredients, which—

''(i) contains a caloric sweetener, and

''(ii) is intended for use as an ingredient in a liquid described in subparagraph (A).

''(2) EXCEPTIONS.—The following shall not be treated as liquids described in paragraph (1)(A):

''(A) Any liquid the primary ingredients of which are milk or soy, rice, or similar plant-based milk substitute.

''(B) Any liquid composed entirely of one or more of the following:

''(i) The original liquid resulting from the pressing of fruit or vegetables.

''(ii) The liquid resulting from the reconstitution of fruit or vegetable juice concentrate.

''(iii) The liquid resulting from the restoration of water to dehydrated fruit or vegetable juice.

''(C) Infant formula.

''(D) Any liquid products manufactured for use as—

''(i) an oral nutritional therapy for persons who cannot absorb or metabolize dietary nutrients from food or beverages,

''(ii) a source of necessary nutrition used due to a medical condition, or

''(iii) an oral electrolyte solution for infants and children formulated to prevent dehydration due to illness.

''(E) Any liquid with respect to which tax is imposed under chapter 51 (relating to distilled spirits, wines, and beer) or under section 7652 by reason of the tax imposed under chapter 51 being imposed on like articles of domestic manufacture.

''(b) CALORIC SWEETENER.—For purposes of this part, the term 'caloric sweetener' means monosaccharides, disaccharides, and high-fructose corn syrup.

''SEC. 4173. SPECIAL RULES.

''(a) SWEETENER TAXED ONLY ONCE.—In the case of any specified sugar-sweetened beverage product which is manufactured or produced by including one or more other specified sugar-sweetened beverage products, no tax shall be imposed under this section on any caloric sweetener contained in the resulting specified sugar-sweetened beverage product if tax was previously imposed under this section on such caloric sweetener when contained in the specified sugar-sweetened beverage product so included.

''(b) INFLATION ADJUSTMENT.—In the case of any sale after December 31, 2015, the one cent amount in section 4171(b) shall be increased by an amount equal to—

''(1) such amount, multiplied by

''(2) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such sale occurs, determined by substituting 'calendar year 2014' for 'calendar year 1992' in subparagraph (B) thereof.

Any increase determined under this subsection shall be rounded to the nearest multiple of one-tenth of a cent.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 4221(a) is amended by adding at the end the following: ''Paragraphs (1), (4), (5), and (6) shall not apply to the tax imposed under section 4171.''.

(2) The table of parts for subchapter D of chapter 32 of such Code is amended by inserting after the item relating to part I the following new item:

''PART II—SUGAR-SWEETENED BEVERAGES''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall take effect on the date of the enactment of this Act.

(2) EXCISE TAX.—The amendments made by subsections (a) and (b) shall apply to sales after the date of the enactment of this Act.

SEC. 210. REPEAL OF EXCISE TAX ON HIGH-COST EMPLOYER-SPONSORED HEALTH COVERAGE.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 is amended by striking section 4980I.

(b) CONFORMING AMENDMENT.—Section 6051 of such Code is amended—

(1) in paragraph (14) of subsection (a), by striking ''section 4980I(d)(1)'' and inserting ''subsection (g)'', and

(2) by adding at the end the following:

''(g) APPLICABLE EMPLOYER-SPONSORED COVERAGE.—For purposes of subsection (a)(14)—

''(1) IN GENERAL.—The term 'applicable employer-sponsored coverage' means, with respect to any employee, coverage under any group health plan made available to the employee by an employer which is excludable from the employee's gross income under section 106, or would be so excludable if it were employer-provided coverage (within the meaning of such section 106).

''(2) EXCEPTIONS.—The term 'applicable employer-sponsored coverage' shall not include—

"(A) any coverage (whether through insurance or otherwise) described in section 9832(c)(1) (other than subparagraph (G) thereof) or for long-term care;

"(B) any coverage under a separate policy, certificate, or contract of insurance which provides benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth) or for treatment of the eye; or

"(C) any coverage described in section 9832(c)(3) the payment for which is not excludable from gross income and for which a deduction under section 162(l) is not allowable.

"(3) COVERAGE INCLUDES EMPLOYEE PAID PORTION.—Coverage shall be treated as applicable employer-sponsored coverage without regard to whether the employer or employee pays for the coverage.

"(4) GOVERNMENTAL PLANS INCLUDED.—Applicable employer-sponsored coverage shall include coverage under any group health plan established and maintained primarily for its civilian employees by the Government of the United States, by the government of any State or political subdivision thereof,

or by any agency or instrumentality of any such government.

''(5) COST OF COVERAGE.—

''(A) HEALTH FSAS.—In the case of applicable employer-sponsored coverage consisting of coverage under a flexible spending arrangement (as defined in section 2205(g)), the cost of the coverage shall be equal to the amount determined under rules similar to the rules of section 4980B(f)(4) with respect to any reimbursement under the arrangement reduced by the contributions described in subsection (a)(14)(B).

''(B) ARCHER MSAS AND HSAS.—In the case of applicable employer-sponsored coverage consisting of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the cost of the coverage shall be equal to the amount of employer contributions under the arrangement until the termination of HSAs as described under section 206 of such Act.

''(C) ALLOCATION ON A MONTHLY BASIS.—If cost is determined on other than a monthly basis, the cost shall be allocated to

months in a taxable period on such basis as the Secretary may prescribe.''.

(c) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code is amended by striking the item relating to section 4980I.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2019.

TITLE III—DRUG-RELATED PROVISIONS

SEC. 301. ESTABLISHMENT OF THE PRESCRIPTION DRUG AND MEDICAL DEVICE REVIEW BOARD.

There is established in the Department of Health and Human Services a board to be known as the Prescription Drug and Medical Device Price Review Board (in this Act referred to as the ''Board'').

SEC. 302. MEMBERSHIP; STAFF.

(a) MEMBERS.—The Board shall be composed of the members as follows:

(1) The Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services (or the Assistant Secretary's designee).

(2) The Administrator of the Centers for Medicare & Medicaid Services or, beginning with 2022,

the Administrator of the Center for Health Care (or the Administrator's designee).

(3) The Assistant Director for the Health Services Division of the Federal Bureau of Prisons (or the Assistant Director's designee).

(4) The Secretary of Defense (or the Secretary's designee).

(5) The Secretary of Veterans Affairs (or the Secretary's designee).

(6) The Commissioner of Food and Drugs (or the Commissioner's designee).

(7) The Director of the National Institutes of Health (or the Director's designee).

(b) CHAIRPERSON.—The Board shall designate 1 member of the Board to serve as the chairperson.

(c) DIRECTOR AND STAFF.—

(1) DIRECTOR.—The Board shall have a director who shall be appointed by the chairperson of the Board, subject to rules prescribed by the Board.

(2) STAFF.—The director may appoint and fix the pay of such additional personnel as the chairperson considers appropriate, subject to rules prescribed by the Board.

(3) APPLICABILITY OF CERTAIN CIVIL SERVICE LAWS.—The director and staff of the Board shall be

appointed subject to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid in accordance with the requirements of chapter 51 and subchapter III of chapter 53 of such title relating to classification and General Schedule pay rates; except that an individual so appointed may not receive pay in excess of the maximum annual rate of basic pay payable for grade GS–15 of the General Schedule.

(d) ASSISTANCE FOR THE BOARD.—Subject to section 306(g), in carrying out this title, the Board—

(1) may seek assistance from outside experts in the fields of consumer advocacy, medicine, pharmacology, pharmacy, and prescription drug reimbursement; and

(2) shall establish and maintain an advisory group and a stakeholder group for purposes of seeking such assistance.

(e) INITIAL MEETING.—The Board shall hold its initial meeting not later than 90 days after the date of the enactment of this Act.

(f) BANNED INDIVIDUALS.—

(1) DRUG COMPANY LOBBYISTS.—No former registered drug manufacturer lobbyist—

(A) may be appointed to the position of Director of the Office; or

(B) may be employed by the Office during the 6-year period beginning on the date on which the registered lobbyist terminates its registration in accordance with section 4(d) of the Lobbying Disclosure Act of 1995 (2 U.S.C. 1603(d)) or the agent terminates its status, as applicable.

(2) SENIOR EXECUTIVES OF LAW-BREAKING COMPANIES.—No former senior executive of a covered entity—

(A) may be appointed to the position of Director of the Office; or

(B) may be employed by the Office during the 6-year period beginning on the later of—

(i) the date of the settlement; and

(ii) the date on which the enforcement action has concluded.

(3) COVERED ENTITY.—The term ''covered entity'' means any entity that is—

(A) a drug manufacturer; and

(B)(i) operating under Federal settlement, including a Federal consent decree; or

(ii) the subject of an enforcement action in a court of the United States or by an agency.

SEC. 303. PROHIBITION AGAINST EXCESSIVE PRICE.

(a) PROHIBITION.—Beginning on the effective date of the regulation required by subsection (b), the manufacturer of a prescription drug or medical device shall not charge an excessive price, as determined pursuant to such regulation, for such drug or device.

(b) FORMULA.—The Board shall by regulation prescribe a formula for determining whether the average manufacturer price of such drug or device over an annual quarter is an excessive price.

(c) DETERMINATION OF EXCESSIVE PRICE.—If the Board determines, on its own initiative or in response to a petition submitted under subsection (d), that the manufacturer of a prescription drug or medical device charges an excessive price for such drug or device in violation of subsection (a)—

(1) the Board shall give the manufacturer—

(A) notice of such violation; and

(B) subject to subsection (d), a period to correct such violation; and

(2) if the manufacturer fails to correct the violation by the end of such period, the manufacturer shall be subject to section 304, section

1927(c)(2)(E) of the Social Security Act (as added by subsection (c) of section 304), and section 4192 of the Internal Revenue Code of 1986, as added by subsection (d) of section 304.

(d) PETITIONS.—Any person may petition the Board to make a determination under subsection (c) regarding the pricing of a prescription drug or medical device. Not later than 90 days after the date of receipt of such a petition, the Board shall—

(1) make a determination under subsection (c) regarding such pricing; or

(2) decline to make such a determination.

(e) CONTINUING VIOLATION.—The Board shall not be required to give a manufacturer an opportunity to correct a violation, as described in subsection (c)(1)(B), before the manufacturer becomes subject to the provisions described in subsection (c)(2) for such violation, if—

(1) the Board has already provided such an opportunity to correct to the manufacturer; and

(2) the Board finds that the violation of subsection (a) is a continuation of an earlier violation with respect to which such an opportunity was provided.

(f) CONSIDERATIONS.—The formula required by subsection (a) shall at a minimum take into consideration—

(1) the average manufacturer price of the prescription drug or medical device over the respective annual quarter or quarters;

(2) the average manufacturer price of other prescription drugs or medical devices in the same therapeutic class over the same quarter or quarters;

(3) the average price at which the prescription drug or medical device and other prescription drugs and medical devices in the same therapeutic class have been sold by manufacturers in countries other than the United States;

(4) the costs associated with producing and marketing the prescription drug or medical device, the value of the drug or device to patients where sufficient data is available to determine such value, the total Federal investment in the development of the drug or device, the size of the patient population receiving the drug or device, and other factors determinative as to the true cost of production; and

(5) whether the price of the prescription drug or medical device increased during any annual quarter by a percentage that is more than 2 percent greater than the CPI increase percentage (as defined in section 215(i) of the Social Security Act (42 U.S.C. 415)) for the respective annual quarter.

(g) VALUE OR COST-EFFECTIVENESS ASSESSMENTS.—The use of Quality-Adjusted Life Years, Disability-Adjusted Life Years, or other similar mechanisms is prohibited for use in value or cost-effectiveness assessments for purposes of this section.

SEC. 304. ENFORCEMENT PROVISIONS.

(a) REDUCED PATENT TERM.—If the Board finds that the manufacturer of a prescription drug or medical device, who is also an owner of a patent for such drug or device, charged an excessive price for such drug or device in violation of section 303(a), the Board may—

(1) reduce the term, by not more than 5 years, of any patent issued under title 35, United States Code, relating to such drug or device; or

(2) if the term of each patent for such drug or device has expired, reduce the term, by not more than 5 years, of another patent owned by the patent owner relating to a prescription drug or medical device.

(b) CIVIL PENALTIES.—If the Board determines under section 303(c) that a manufacturer of a prescription drug or medical device charged an excessive price for a prescription drug or medical device in violation of section 303(a), the Board may impose a civil penalty on the manufacturer of not more than 10 percent of the manufactur-

er's gross sales of the drug or device during the period beginning on the date on which an excessive price is first charged and ending on the date on which the manufacturer ceases to charge an excessive price.

(c) TAX ON EXCESS PRESCRIPTION DRUG AND MEDICAL DEVICE PROFITS.—

(1) DETERMINATION OF AMOUNT.—If the Board determines under section 303(a) that a manufacturer, producer, or importer of a prescription drug or medical device charged an excessive price for such prescription drug or medical device during a taxable year, the Board may determine under this paragraph a reasonable price for such drug or device for such taxable year.

(2) IMPOSITION OF TAX.—

(A) IN GENERAL.—The Internal Revenue Code of 1986 is amended by inserting after section 4191 the following new section:

"SEC. 4192. EXCESSIVE PRESCRIPTION DRUG AND MEDICAL DEVICE PRICE.

''(a) IN GENERAL.—There is hereby imposed on the sale of any prescription drug or medical device by the manufacturer, producer, or importer a tax equal to the difference between the price at which such drug or device is so sold and the reasonable price determined by the Pre-

scription Drug and Medical Device Price Review Board under section 303(c)(1) of the Medicare for America Act for such drug or device for the taxable year for sales after the determination.

''(b) PRESCRIPTION DRUG OR MEDICAL DEVICE.—For purposes of this section, the term 'prescription drug or medical device' means any prescription drug (as defined in section 9008 of the Patient Protection and Affordable Care Act) or device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act) intended for humans.''.

(B) CLERICAL AMENDMENT.—The table of parts for chapter 32 of such Code is amended—

(i) in the item relating to subchapter E, by striking ''Medical'' and inserting ''Drugs and medical''; and

(ii) by inserting after the item relating to section 4191 the following new item:

''Sec. 4192. Excessive prescription drug and medical device price.''.

(3) EFFECTIVE DATE.—This subsection and the amendments made by this subsection shall apply with respect to sales after December 31, 2019.

SEC. 305. AUTHORITY.

(a) OBTAINING OFFICIAL DATA.—The chairperson of the Board may secure directly from any Federal agency information necessary to enable the Board to carry out

its duties. Upon request of the chairperson, the head of the agency shall furnish such information to the Board to the extent such information is not prohibited from disclosure by law.

(b) MAILS.—The Board may use the United States mails in the same manner and under the same conditions as other Federal agencies.

(c) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the chairperson of the Board, the Administrator of General Services shall provide to the Board, on a reimbursable basis, the administrative support services necessary for the Board to carry out its duties.

(d) CONTRACT AUTHORITY.—The Board may contract with and compensate government and private agencies or persons for the purpose of conducting research, surveys, and other services necessary to enable the Board to carry out its duties.

(e) INVESTIGATIONS.—The Board may make such investigations as it considers necessary to determine whether there is or may be a violation of any regulation promulgated under this Act and may require or permit any person to file with it a statement in writing, under oath or otherwise as the Board shall determine, as to all the facts and circumstances concerning the matter to be investigated.

(f) SUBPOENA POWER.—

(1) IN GENERAL.—The Board may issue subpoenas requiring the attendance and testimony of witnesses and the production of any evidence relating to any matter under investigation by the Board. The attendance of witnesses and the production of evidence may be required from any place within the United States at any designated place of hearing within the United States.

(2) FAILURE TO OBEY A SUBPOENA.—If a person refuses to obey a subpoena issued under paragraph (1), the Board may apply to a United States district court for an order requiring that person to appear before the Board to give testimony, produce evidence, or both, relating to the matter under investigation. The application may be made within the judicial district where the hearing is conducted or where that person is found, resides, or transacts business. Any failure to obey the order of the court may be punished by the court as civil contempt.

(3) SERVICE OF SUBPOENAS.—The subpoenas of the Board shall be served in the manner provided for subpoenas issued by a United States district court under the Federal Rules of Civil Procedure for the United States district courts.

(4) SERVICE OF PROCESS.—All process of any court to which application is made under paragraph (2) may be served in the judicial district in which the person required to be served resides or may be found.

(5) NOTICE.—Upon issuing any subpoena under this subsection, the Board shall give notice of such issuance to the appropriate committees of Congress, including the Committee on Appropriations of the House of Representatives and the Committee on Appropriations of the Senate.

(g) CONFIDENTIALITY.—Under this title, the Secretary shall enforce applicable law concerning a trade secret or confidential information subject to section 552(b)(4) of title 5, United States Code, or section 1905 of title 18.

SEC. 306. REGULATIONS.

(a) IN GENERAL.—Not later than 1 year after the date of the initial meeting held under section 302(e), the Board shall issue final regulations to carry out this Act.

(b) NOTICE AND COMMENT REQUIREMENT.—The regulations developed under subsection (a) shall be issued in accordance with the notice and comment procedures established under section 553 of title 5, United States Code.

SEC. 307. REPORT TO FEDERAL AGENCIES.

Not later than 1 year after the effective date of the regulations under section 306 and annually thereafter, the Board shall submit to each Federal agency that dispenses or makes payments for the dispensing of prescription drugs or medical devices a report containing a list of each prescription drug and medical device for which an excessive price was charged during the preceding calendar year, as determined by the Board under section 303. The Secretary shall make this report publicly available.

SEC. 308. DEFINITIONS.

In this title:

(1) AFFILIATE.—The term ''affiliate'' means, with respect to a manufacturer, any entity that controls, is controlled by, or is under common control with such manufacturer.

(2) AVERAGE MANUFACTURER PRICE.—The term ''average manufacturer price'' means the average price charged by the manufacturer of a prescription drug or medical device, as applicable, for sales of the drug or device by the manufacturer in the United States over the respective annual quarter.

(3) MEDICAL DEVICE.—The term ''medical device'' means a device (as defined in section 201 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321)).

(4) PRESCRIPTION DRUG.—The term ''prescription drug'' means a drug (as defined in section 201 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321)) that is subject to section 503(b)(1) of such Act (21 U.S.C. 353(b)(1)).

(5) MANUFACTURER.—The term ''manufacturer'' means the person—

(A) that holds the application for a drug approved under section 505 of the Federal Food, Drug, and Cosmetic Act or the license issued under section 351 of the Public Health Service Act; or

(B) who is responsible for setting the price for the drug.

(6) WHOLESALE ACQUISITION COST.—The term ''wholesale acquisition cost'' has the meaning given that term in section 1847A(c)(6)(B) of the Social Security Act (42 U.S.C. 1395w–3a(c)(6)(B)).

SEC. 309. MORATORIUM ON DIRECT-TO-CONSUMER DRUG ADVERTISING.

The Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) is amended—

(1) in section 301 (21 U.S.C. 331), by adding at the end the following:

''(eee) The conduct of direct-to-consumer advertising of a drug in violation of section 506J.''; and

(2) in chapter V, by inserting after section 506I (21 U.S.C. 356f) the following:

''SEC. 506J. DIRECT-TO-CONSUMER DRUG ADVERTISING.

''(a) PROHIBITIONS.—

''(1) FIRST THREE YEARS.—

''(A) IN GENERAL.—Subject to subparagraph (B), no person shall conduct direct-to-consumer advertising of a drug for which an application is submitted under section 505(b) before the end of the 3-year period beginning on the date of the approval of such application.

''(B) WAIVER.—The Secretary may waive the application of subparagraph (A) to a drug during the third year of the 3-year period described in such subparagraph if—

''(i) the sponsor of the drug submits an application to the Secretary pursuant to subparagraph (C); and

''(ii) the Secretary, after considering the application and any accompanying materials, determines that direct-to-consumer advertising of the drug would have an affirmative value to public health.

''(C) APPLICATION FOR WAIVER.—To seek a waiver under subparagraph (B), the sponsor of a drug shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

''(2) SUBSEQUENT YEARS.—The Secretary may prohibit direct-to-consumer advertising of a drug during the period beginning at the end of the 3-year period described in paragraph (1)(A) if the Secretary determines that the drug has significant adverse health effects based on post-approval studies, risk-benefit analyses, adverse event reports, the scientific literature, any clinical or observational studies, or any other appropriate resource.

''(b) REGULATIONS.—Not later than 1 year after the date of the enactment of this section, the Secretary shall revise the regulations promulgated under this Act governing drug advertisements to the extent necessary to implement this section.

''(c) RULE OF CONSTRUCTION.—This section shall not be construed to diminish the authority of the Secretary to prohibit or regulate direct-to-consumer advertising of drugs under other provisions of law.''.

SEC. 310. REPORTING ON JUSTIFICATION FOR DRUG PRICE INCREASES.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following:

"PART W—DRUG PRICE REPORTING; DRUG VALUE FUND

"SEC. 399OO. REPORTING ON JUSTIFICATION FOR DRUG PRICE INCREASES.

''(a) DEFINITIONS.—In this section:

''(1) MANUFACTURER.—The term 'manufacturer' means the person—

''(A) that holds the application for a drug approved under section 505 of the Federal Food, Drug, and Cosmetic Act or the license issued under section 351 of the Public Health Service Act; or

''(B) who is responsible for setting the price for the drug.

''(2) QUALIFYING DRUG.—The term 'qualifying drug' means any drug that is approved under subsection (c) or (j) of section 505 of the Federal Food, Drug, and Cosmetic Act or licensed under subsection (a) or (k) of section 351 of this Act—

''(A) that has a wholesale acquisition cost of $100 or more per month supply or per a

course of treatment that lasts less than a month and is—

"(i)(I) subject to section 503(b)(1) of the Federal Food, Drug, and Cosmetic Act; or

"(II) commonly administered by hospitals (as determined by the Secretary);

"(ii) not designated as a drug for a rare disease or condition under section 526 of the Federal Food, Drug, and Cosmetic Act; and

"(iii) not designated by the Secretary as a vaccine; and

"(B) for which, during the previous calendar year, at least 1 dollar of the total amount of sales were for individuals enrolled under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) or under a State Medicaid plan under title XIX of such Act (42 U.S.C. 1396 et seq.) or under a waiver of such plan.

"(3) WHOLESALE ACQUISITION COST.—The term 'wholesale acquisition cost' has the meaning given that term in section 1847A(c)(6)(B) of the Social Security Act (42 U.S.C. 1395w–3a(c)(6)(B)).

''(b) REPORT.—

''(1) REPORT REQUIRED.—The manufacturer of a qualifying drug shall submit a report to the Secretary for each price increase of a qualifying drug that will result in an increase in the wholesale acquisition cost of that drug that is equal to—

''(A) 10 percent or more over a 12-month period; or

''(B) 25 percent or more over a 36-month period.

''(2) REPORT DEADLINE.—Each report described in paragraph (1) shall be submitted to the Secretary not later than 30 days prior to the planned effective date of such price increase.

''(c) CONTENTS.—A report under subsection (b) shall, at a minimum, include—

''(1) with respect to the qualifying drug—

''(A) the percentage by which the manufacturer will raise the wholesale acquisition cost of the drug on the planned effective date of such price increase;

''(B) a justification for, and description of, each manufacturer's price increase that will occur during the 12-month period described in

subsection (b)(1)(A) or the 36-month period described in subsection (b)(1)(B), as applicable;

"(C) the identity of the initial developer of the drug;

"(D) a description of the history of the manufacturer's price increases for the drug since the approval of the application for the drug under section 505 of the Federal Food, Drug, and Cosmetic Act or the issuance of the license for the drug under section 351, or since the manufacturer acquired such approved application or license;

"(E) the current list price of the drug;

"(F) the total expenditures of the manufacturer on—

"(i) materials and manufacturing for such drug; and

"(ii) acquiring patents and licensing for such drug;

"(G) the percentage of total expenditures of the manufacturer on research and development for such drug that was derived from Federal funds;

"(H) the total expenditures of the manufacturer on research and development for such drug that is used for—

"(i) basic and preclinical research;

"(ii) clinical research;

"(iii) new drug development;

"(iv) pursuing new or expanded indications for such drug through supplemental applications under section 505 of the Federal Food, Drug, and Cosmetic Act or section 351 of the Public Health Service Act; and

"(v) carrying out postmarket requirements related to such drug, including those under section 505(o)(3) of the Federal Food, Drug, and Cosmetic Act;

"(I) the total revenue and the net profit generated from the qualifying drug for each calendar year since the approval of the application for the drug under section 505 of the Federal Food, Drug, and Cosmetic Act or the issuance of the license for the drug under section 351, or since the manufacturer acquired such approved application or license; and

"(J) the total costs associated with marketing and advertising for the qualifying drug;

"(2) with respect to the manufacturer—

"(A) the total revenue and the net profit of the manufacturer for each of the 12- and 36-month periods preceding the submission of the report;

"(B) all stock-based performance metrics used by the manufacturer to determine executive compensation for each of the 12- and 36-month periods preceding the submission of the report; and

"(C) any additional information the manufacturer chooses to provide related to drug pricing decisions, such as total expenditures on—

"(i) drug research and development; or

"(ii) clinical trials on drugs that failed to receive approval by the Food and Drug Administration; and

"(3) such other related information as the Secretary considers appropriate.

"(d) CIVIL PENALTY.—Any manufacturer of a qualifying drug that fails to submit a report for the drug as

required by this section shall be subject to a civil penalty of $100,000 for each day on which the violation continues.

''(e) PUBLIC POSTING.—

''(1) IN GENERAL.—Subject to paragraph (3), not later than 30 days after the submission of a report under subsection (b), the Secretary shall post the report on the public website of the Department of Health and Human Services.

''(2) FORMAT.—In developing the format of such report for public posting, the Secretary shall consult stakeholders, including beneficiary groups, and shall seek feedback on the content and format from consumer advocates and readability experts to ensure such public reports are user-friendly to the public and are written in plain language that consumers can readily understand.

''(3) TRADE SECRETS AND CONFIDENTIAL INFORMATION.—In carrying out this section, the Secretary shall enforce applicable law concerning the protection of confidential commercial information and trade secrets.

''SEC. 399OO–1. USE OF CIVIL PENALTY AMOUNTS.

''The Secretary shall, without further appropriation, collect civil penalties under section 399OO and use the funds derived from such civil penalties, in addition to any

other amounts available to the Secretary, to carry out activities described in this part and to improve consumer and provider information about drug value and drug price transparency.

"SEC. 399OO–2. ANNUAL REPORT TO CONGRESS.

''(a) IN GENERAL.—Subject to subsection (b), the Secretary shall submit to Congress, and post on the public website of the Department of Health and Human Services in a way that is easy to use and understand, an annual report—

''(1) summarizing the information reported pursuant to section 399OO; and

''(2) including copies of the reports and supporting detailed economic analyses submitted pursuant to such section.

''(b) TRADE SECRETS AND CONFIDENTIAL INFORMATION.—In carrying out this section, the Secretary shall enforce applicable law concerning the protection of confidential commercial information and trade secrets.''.

TITLE IV—OUTCOMES AND REPORTING

SEC. 401. SENSE OF CONGRESS.

It is the sense of Congress that Medicare for America will have a significant impact on the health and well-being of the United States population and the social deter-

minants of the health of beneficiaries of Medicare for America.

SEC. 402. EVALUATION OF BILL'S OUTCOME.

(a) IN GENERAL.—To assess the impact of this Act on the health of the population, not later than 2 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall allow for analysis of administrative records that have removed all personally identifiable information from the Center for Health Care to existing population surveys conducted by the Federal Government and federally supported surveys.

(b) CDC AND NIH.—The Directors of the Centers for Disease Control and Prevention and the National Institutes of Health shall solicit a comprehensive, longitudinal study to evaluate any differential individual impact on coverage expansion based on—

(1) race and ethnicity;

(2) socioeconomic status; or

(3) health status.

(c) REPORT.—Ten years after the date of the enactment of this Act and every ten years thereafter, the Secretary shall submit a report to the House Committee on Energy and Commerce and the Senate Committee on Health, Education, Labor, and Pensions regarding impact of this Act on the health of the United States population

based on the results of subsection (b) contributions from all other relevant agencies.

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